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*Rehabilitation Literature* is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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# REHABILITATION LITERATURE

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## CONTENTS

July, 1961, Volume 22, No. 7

### Page

Article of the Month	198
----------------------	-----

A Report on the Epilepsy Problem, by George N. Wright, Ph.D.

Review of the Month	206
---------------------	-----

*Understand Those Feelings; A Guide for Parents of Handicapped Children and Everyone Who Counsels Them*, by Eugene T. McDonald, Ed.D.

*Reviewed by*: Darrel J. Mase, Ph.D.

Other Books Reviewed	209
----------------------	-----

Digests of the Month	212
----------------------	-----

Reading for Handicapped Children, by Olle Wingborg

In: *Illinois Libraries*. Apr., 1961. 43:4:235-241.

Comprehensive Prosthetic Care (Chapter 3)

In: *Sixth Annual Report, 1960, Child Amputee Prosthetics Project*

Published by: Dept. of Pediatrics, School of Medicine,  
University of California at Los Angeles

Abstracts of Current Literature	215
---------------------------------	-----

Events and Comments	228
---------------------	-----

### Author Index

### Inside Back Cover

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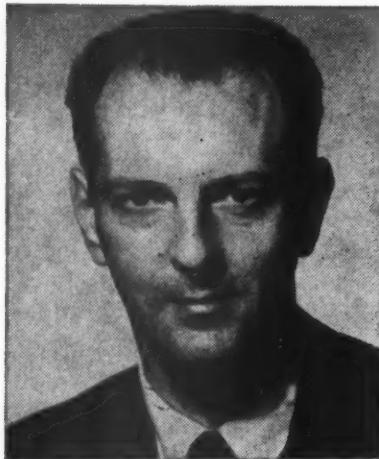
197

# REHABILITATION LITERATURE

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## Article of the Month

### A Report on the Epilepsy Problem



#### About the Author . . .

Dr. Wright is national program director of the National Epilepsy League, Chicago. His background includes several years' experience as a state vocational rehabilitation counselor and as a research fellow of the U.S. Office of Vocational Rehabilitation. He completed his undergraduate training at Indiana University and received his M.S. (1954) and Ph.D. (1959) degrees in psychology at Purdue University. Dr. Wright and Dr. H. H. Remmers are the authors of the *Handicap Problems Inventory*, a new instrument to measure problems associated with disability, published by the Purdue Research Foundation. The 1960 national institute on the rehabilitation of epileptics, sponsored by the National Epilepsy League, the School of Medicine of the University of Illinois, and the U.S. Office of Vocational Rehabilitation, was under Dr. Wright's chairmanship; he is editor of the forthcoming book based on the proceedings. He is a member of the American Psychological Association, National Council on Psychological Aspects of Disability, American Personnel and Guidance Association, National Vocational Guidance Association, National Rehabilitation Association, American Epilepsy Society, and Society of Sigma Xi.

This original article was written especially for Rehabilitation Literature.

George N. Wright, Ph.D.

PROFESSIONAL WORKERS for the handicapped have long combated negative public attitudes surrounding disability and have made great progress. Unfortunately, acceptance of epilepsy has not kept pace with the improved acceptance accorded other forms of disability. The mere label brings social rejection and epilepsy remains the major hush-hush disorder affecting large numbers of people. A more effective program to educate the public to a modern view of epilepsy must be developed and supported by rehabilitation workers.

The purpose of this paper is to clarify facts about epilepsy for an informed approach to the disability and its associated handicaps, the most pervasive of which is the social stigma. Few disabilities are so misunderstood by the public. None arouses such irrational fear. The outcome of this ignorance and associated fear is the wall of public prejudice faced by every person known to be epileptic. Any review of the nonmedical literature on epilepsy makes this quite clear.<sup>13, 39</sup> Those who would serve the epileptic individual must know and must cope with this barrier to integration.

The emotional response toward epilepsy is deep-rooted. Epilepsy is as old as man—in fact, it predates human life. From the beginning of recorded history it was regarded as an omen, a curse, the work of spirits, something fallen upon man, something that seized him from without.<sup>31</sup> Hippocrates (c. 460-c. 377 B.C.) observed that epilepsy was due to medical rather than supernatural causes. Yet, up to the turn of the 18th century, people commonly believed that those with epilepsy were possessed of the devil and only death would stop the evil they spread. The text of Mosaic law, "Thou shalt not suffer a witch to live," was cited when many were prosecuted as witches in our own infamous Salem trials of 1692.

Perhaps modern man no longer believes in witches, but the blanket of stigma upon the epileptic has changed little. Experience moved one

person to say, "Epilepsy is not a diagnosis—it is an accusation." Irrespective of the degree of actual limitation, the label itself is a handicap. The public's false concept is most epileptics' greatest handicap. For many it is their sole limitation to normal living.

To destroy this false image of epilepsy, its great variations must be made known, for in any fight against prejudice we cope with the tendency to see only group characteristics. To do this we emphasize individual differences. This paper centers on the fact that epilepsy takes many different forms. Blanket evaluation is even less valid than with other disablements. Epilepsy must be regarded in terms of the type and degree of actual limitation imposed in specific cases.

Acceptance generally follows understanding. Human fear of the unknown is particularly powerful when it concerns the brain and its dramatic malfunction, the epileptic convulsion. Epilepsy is complex, in both cause and its many manifestations. Since it is not easily understood even in the light of present-day knowledge, the lag is great between scientific understanding of epilepsy and emotional reaction. This paper attempts to provide an overview of the total epilepsy problem. Throughout the discussion of almost any aspect of epilepsy, the matter of stigma is most striking in its inseparable and practical significance. May the rehabilitationist be moved.

#### Prevalence and Incidence in the United States

Estimates of the prevalence of epilepsy are influenced by the understandable reluctance of people with the disorder to reveal their condition. This is complicated by the frequency of undiagnosed cases and by problems of definition.

Case finding is a major obstacle in any attempt to estimate the number of persons who have epilepsy.<sup>2</sup> The writer<sup>38</sup> has published a self-report device to identify students with any handicapping disability. Trial administrations of the primary form showed that many teen-agers with epilepsy use a substitute term such as fainting spell or blackout instead of epileptic seizure and are uninformed as to the nature of their condition. Often a kindly physician does not report the diagnosis even to parents. If the parents know, they are inclined to keep it secret.

The death of the quintuplet, Emily Dionne, from suffocation in her pillow during an epileptic seizure shocked the world. Her seizures had been kept a closely guarded secret. There are many people of fame with epilepsy, yet few are known by the public. Generally, newspaper men protect public figures with the disorder. Even now it is not generally known that one of the most important presidents of the United States in this century was epileptic.

The same is true of the average epileptic. The condition is kept secret by those who can. Unpublished research showed that the majority of sufferers get driver's licenses,

marriage licenses, life and auto insurance policies, jobs, and other rights or privileges by simply not telling.

Fear of disclosure is so great that many attribute their seizures to such socially acceptable conditions as heart disease or diabetes. Schechter<sup>28</sup> recounts a mother's expression of relief in learning that her child, who was first thought to be epileptic, was instead paranoid. Epilepsy agencies are forced to use plain envelopes in deference to the wishes of those who do not want even the postman to guess that they have made a personal inquiry. So great is this desire for secrecy that many epileptics turn to mail-order doctors in distant cities, who treat them without personal examination.

Typical health survey methods, for these reasons, do not uncover most cases of epilepsy. Our available data are based on circumstances involving a compelling reason for the epileptic to identify himself.

A report by the World Health Organization<sup>36</sup> states that about 6 percent of the total population, including children and adults, have had some sort of convulsive episode at some time in their lives. This is not to say that 6 of 100 people are epileptic. In many cases the epilepsy is active for only a short period of the person's life. Then, too, the scope of the term epilepsy is not precisely defined, and attempts are often made to separate convulsions (especially those of infancy), despite the fact they have the same physiological mechanism.

The figure of one percent of the population is commonly given as the approximate prevalence of epilepsy, the source being United States armed services draft and medical discharge data recorded during world wars (adjusted for the age factor).

A more conservative estimate, based on a longitudinal study conducted with Rochester, Minn., residents, was recently reported by Kurland.<sup>17</sup> Incidence (number of new cases) in the United States annually as projected from the Rochester sample is 52,000 persons; at the .95 level of significance, between 24.5 and 37.1 persons per 100,000 population are estimated to be newly affected in the United States each year. Kurland acknowledges that these data are below the true rate: There is no assurance that all epileptics in the community were identified at the clinic and, out of 336 cases over the 10-year period, only 194 were included as clinically acceptable; *i.e.*, suspect cases with uncertain diagnosis, as well as infants and children with febrile convulsions, were excluded.

Even accepting the most conservative estimates, epilepsy is numerically important.

#### Causes and Types of Epilepsy

Epileptic patients share one major problem: the erroneous public image of epilepsy. The public thinks of an epileptic as a person with gross brain damage, uncontrolled convulsions, psychic peculiarities, and mental retardation. Although only a small percentage of epileptics are so

## ARTICLE OF THE MONTH

severely disabled, they make an indelible impression upon the public. Each person having epilepsy bears the same label, but there the similarity ends.

Actually epilepsy is a highly individualized disorder. More than a dozen seizure types have been named to differentiate classic patterns. Seizures may also be classified in other ways, viz., anatomically with reference to cerebral localization, etiologically as to genetic or acquired causation, electroencephalographically from the standpoint of seizure discharge pattern, therapeutically in terms of response to antiseizure drugs, or socially according to impact of the seizure upon life adjustment.

The complexity of causes and manifestations has given scholars great difficulty in stating a definition of epilepsy. Even now there is not universal agreement. Some would equate the term epilepsy to the observed phenomena. Others think of it as the disease. It would seem best, in the interest of practical semantics, to reserve the word epilepsy for the underlying condition or conditions and to use seizure to refer to the outward symptoms. This distinction between *epilepsy*, meaning the disease, and *seizure*, meaning symptom, does not require perfect knowledge of root causes based on the chemistry or metabolism of neurons.<sup>32</sup> The term paroxysmal cerebral dysrhythmia proposed by Gibbs, Gibbs, and Lennox<sup>11</sup> stresses the immediate cause of epilepsy. It points up the fact that seizures and the form they take depend upon an underlying difficulty in the brain associated with an abnormal electrical disturbance (dysrhythmia).

If the disturbance is confined to just one portion of the brain, the epilepsy may manifest itself as a visual or other sensation, emotion or peculiar behavior, pain, fever, dizziness, or convulsive movements on one side of the body. The characteristics of these *focal* seizures reveal the area of the brain affected. For example, psychomotor attacks, periods of peculiar behavior, originate from discharges in the temporal lobe or its immediate vicinity. Sometimes a focal seizure such as jerking or twitching on one side or part of the body—Jacksonian seizure—spreads to the rest of the body as the disturbance spreads in the brain.

Grand mal seizures are *convulsions* that occur when an excessive release of electrical energy is generalized in the brain. The person loses consciousness, and there is abnormal muscle action, first rigidity (tonic state), then jerking (clonic movement). There may be throat noises and dusky color due to breathing irregularities, excessive saliva, vomiting, loss of bladder or bowel control, and biting of tongue. About half of these patients experience an "aura," an unexplained warning sensation, such as a queer feeling, dizziness, numbness, sickness, or vague fear. When the local disturbance responsible for the aura spreads, a grand mal convulsion occurs.

Brain dysrhythmia is also commonly generalized in petit mal, but it is cut short before a convulsion develops.

There is brief, but often frequent, loss or impairment of consciousness, usually with rhythmical blinking of eyes and jerking of arms with or without falling. As Gibbs and Stamps<sup>12</sup> have pointed out, just as focal seizures are limited according to the area or amount of the brain involved, the generalized disruption of petit mal is limited by time and is checked before it develops into a convolution.

There are other seizure forms. Myoclonic epilepsy is characterized by brief attacks as a sudden jerk of the head, limbs, or trunk. The petit mal variant form resembles true petit mal but ordinarily occurs at a younger age, with brain damage, and has a poorer prognosis, since intellectual impairment and uncontrollable convulsions are common. Hypsarrhythmia or infantile spasms are ordinarily attributed to early brain damage; with them prognosis is least hopeful. Febrile convulsions involve an inherited tendency for convulsive attacks with fever. Thalamic and hypothalamic seizures include attacks of dizziness, sweating, heart palpitation, paresthesias, rage, and other disturbances that are often not diagnosed as epileptic.

The etiology of epilepsy is divided according to hereditary, acquired, and precipitating factors. The three factors are not mutually exclusive and in most cases all enter into the causal chain of events.

At least 3 out of 10 cases of epilepsy show evidence of neuropathological lesion due to head injury, infection, fever, tumor, or circulatory or other conditions in the brain. Many authorities believe most, if not all, epilepsy results from such cause. When brain damage is shown to cause seizures, it is called symptomatic epilepsy, but brain-cell injury responsible for epilepsy is commonly slight and is frequently not identifiable. If an injury cannot be demonstrated, the epilepsy is called idiopathic (of unknown cause). In such cases the seizures may be simply attributed to metabolic disturbance of the brain and the inheritance factor is believed particularly strong.

### Diagnosis and Control

The initial step in the rehabilitation of epileptic persons is obtaining really good medical diagnosis and control. In recent years over a dozen new anticonvulsant drugs have been made available for effective treatment of difficult cases. Diagnostic methods have improved; especially noteworthy is the application of the electroencephalograph, which records the brain's electrical activity. Unfortunately, relatively few physicians specialize in epilepsy, and the United States has only 81 epilepsy clinics.<sup>1</sup> Only 20 percent of people with epilepsy are said to have adequate control, although 50 percent could be rendered seizure-free and in an additional 30 or 35 percent seizures could be reduced in severity or frequency so they would not be incapacitating. (The term seizure-free is applied to those who, with or without anticonvulsants, have not

## ARTICLE OF THE MONTH

experienced a seizure for a minimum of 6 months to 2 years.)

Usually it is advisable to defer long-range planning until maximum control for the epileptic person is established. During the interim both dosage and type of medication are varied by the physician to determine the most satisfactory antiseizure prescriptions. Several months may be required. Meanwhile the prediction of frequency, severity, and time of seizure is quite unreliable and troublesome side reactions to the medicine may occur.

The occurrence and kind of side reaction depend upon type of medication and dosage, as well as the individual's level of tolerance. Possible reactions include drowsiness, ataxia, skin rash, or damage to the liver, kidneys, or nervous system. Because of the toxicity of many antiseizure drugs and the unpredictability of the course of the disorder, one or more physical examinations, possibly with laboratory analyses, are needed annually. It is safe to say, however, that the antiepileptic drugs (in usually prescribed doses) are not habit-forming. (The terms antiseizure, anticonvulsant, and antiepileptic drugs are used interchangeably in this paper.)

The cost of medical treatment varies greatly. The author queried a 2 percent stratified-random sample ( $N=500$ ) of a mailing list of epileptics in the United States about what they paid for anticonvulsants. The cost of their antiepileptic medicine ranged up to over \$500.00 per year; the average annual outlay per patient was nearly \$120.00, this mean being spuriously low because of the inclusion of many persons obtaining medicine at below retail or at no cost (such as Veterans Administration and other hospital or clinic patients). In addition, medical management may include tranquilizers and other drugs. The number of visits to the physician and the amount and frequency of laboratory work such as EEG recordings and blood counts vary considerably from patient to patient. Fortunately, hospitalization is ordinarily unnecessary except for status epilepticus (rapidly recurring convulsive episodes). One aspect of epilepsy is that treatment continues over an extended time, perhaps for life.

The epileptic's role in his treatment program is important. He should understand the neurological basis for his seizures, the procedures for diagnosis and control, and the need for continuing co-operation with his doctor. The physician's instructions concerning medication must be followed religiously. Some epileptics find that using bottles, each filled with a day's supply, helps them to remember. Reducing or stopping anticonvulsant medication without medical advice can be quite harmful. The epileptic's willingness to remain under the personal care of a qualified physician is crucial.

Treatment is primarily with medicines, although in occasional instances brain surgery is a possibility. These cases are selected where there is an operable lesion and after careful consideration of other factors. The percentage

of cases for which surgery is indicated is small. Except for an expanding lesion, it would be considered only after drug therapy failed to effect reasonable control.

Further material of a medical nature regarding epilepsy may be found in any comprehensive neurological text, various books dealing specifically with epilepsy,<sup>4, 7, 9, 10, 12, 14, 18, 26, 30, 32</sup> the journal *Epilepsia*, published by the International League Against Epilepsy, and other neurological and medical journal articles indexed in *Excerpta Medica: Neurology and Psychiatry*.

### Functional Variations

Because the disorder manifests itself in such widely different ways, the plural term epilepsies is often used. Lennox<sup>18</sup> says seizures are composed of any one or more of the following recurrent and involuntary phenomena: loss or derangement of consciousness or remembrance (amnesia); excess or loss of muscle tone or movement; alteration of sensation, including hallucinations of special senses; disturbance of autonomic nervous system; other psychic manifestations, abnormal thought processes or moods.

The most common symptom of epilepsy is loss or impairment of consciousness, but even this is not necessarily a component of focal seizures. In fact consciousness may even be abnormally acute, as in an aura. Seizures range from imperceptible to highly dramatic episodes. One kind of seizure is no more representative of epilepsy than another; there is no typical seizure form.

The degree and the kind of handicap imposed by epilepsy are as varied as seizure characteristics. About a quarter of the patients experience more than one kind of seizure.<sup>25</sup> Grand mal and petit mal are frequently combined or mixed with other kinds of seizures. Psychomotor episodes occur in approximately one third of adult epileptics. Furthermore, the individual's seizure pattern or characteristics may change. Several years' or even permanent remission is not uncommon.

In addition to seizure characteristics, many other variations are of evaluative interest to the rehabilitationist. Paramount are the degree and stability of control. About 50 percent of the cases of epilepsy at this time cannot be completely controlled. Fortunately, many epileptics are able to predict the occurrence of a seizure and can plan accordingly. The aura, which is actually a part of the seizure, occurs just a few moments before a convulsion. (The aura may or may not be followed by a convulsive episode.) This warning signal is experienced by about one half of grand mal epileptics. Other cases have a nocturnal or diurnal pattern from which the likely time of the seizure can be anticipated. Of course there is no absolute assurance that the seizure will occur at the usual time and only then. The reliability of the aura must be evaluated in practical terms.

Precipitating factors may vary from case to case. Physical

## ARTICLE OF THE MONTH

and mental activity, contrary to popular conception, is an important adjunct to effective seizure control. Excessive fatigue or emotional strain, however, can touch off a seizure. Many epileptics must avoid irregularities in work shift or other habits or routines. Excesses such as in use of alcohol are inadvisable. General physical and mental health should be maintained at a high level. Although most have no other handicapping condition, many epileptics have multiple disabilities. Such neurologic conditions as cerebral palsy or mental retardation may occur jointly with symptomatic epilepsy from the original brain damage. Abnormal emotional behavior may be either a direct neurological facet of the epilepsy, as in temporal lobe cases, or an indirect, psychological result of the seizures. In such cases the limitation imposed by an occasional convulsion may be of secondary functional importance to the behavioral or other physical abnormality.

### Psychological Problems

As with other physical disabilities, there may be non-organic personality influences associated with epilepsy. The psychological reaction of the individual to his seizure state is based upon environmental and personal characteristics. Because these vary it is not surprising that research attempts to identify the "epileptic personality" yield conflicting results and fail to agree to a single pattern of personality inherent in epilepsy.<sup>5</sup>

Somatic, structural determinants of deviant behavior such as an underlying organic lesion and toxic effects of medication were mentioned previously. There are also the nonorganic, psychological reaction possibilities. Beatrice Wright<sup>37</sup> shows the problem of uncertainty resulting from a "new psychological situation" that is unclear, unstructured, or ambiguous. It is especially true in epilepsy, because the epileptic is unable to structure his situation in a stable way; at any moment events could shift dangerously beyond his control. Uncertainty is created whenever seizures are not completely controlled and so overtake a person without warning. Even if the epileptic is not beset by insecurity stemming from unexpected seizures, he faces uncertainties of social reception. Ambiguities result from an unstable self-image (for example, he may vacillate between identification with the healthy or with the sick).

Again within the framework of topological psychology, Gertrud Lewin<sup>22</sup> has suggested eight reasons why the situation of epileptics seems to lack cognitive structure over a long period of time.

1. After being given a diagnosis of epilepsy, patients and their families are told there is no cure, but that an attempt will be made to control seizures. This statement, ambiguous to the layman-patient accustomed to thinking of being either healthy or ill, does not help him in orienting himself.

2. The patient finds himself healthy at times and epileptic

at times, with much overlapping. In most types of seizures he does not really experience his illness. Because of this, epileptics feel tension and conflict and tend to vacillate in behavior and give an impression of unreliability.

3. Because the disease has its locus in the brain, patients are not sure whether they are sick physically or mentally. They hope it is a physical condition, but always they fear that they may be mentally ill. Patients told they have an epileptogenic lesion become confused if they are given psychotherapy for a psychological overlay.

4. Clear limits are essential for the happy existence of all people of all ages, but they are seldom available to those with epilepsy. Even if they have made peace with themselves as epileptics, they are unsure of limits as to employment, courtship and marriage, and social groups.

5. The boundaries and barriers experienced by epileptics are intangible. They cannot legally drive vehicles in many states even if they have all the skills and ability to do so. Intellectually they may understand the restrictions, but emotionally they find it incomprehensible.

6. The patients see themselves as isolated because they are excluded from many group activities in which they feel able to participate and because individuals, including their families, segregate them.

7. Identification with other epileptics requires acceptance of their disease, which is difficult in view of all the other problems the disease presents.

8. Time perspective seems elusive for epileptics, their condition tends to have no real end and no reliable specific period of exacerbation or remission. They may be seizure-free for months or years and then have a sudden isolated seizure with all its devastations.

If the onset of epilepsy is in childhood, as is most common, seizures may affect the development of normal emotional maturity. This can stem from parental treatment—overprotection, rejection, indulgence, and similar practices rooted in the parent's misunderstanding, fear, and perhaps guilt. The parents are apt to try to conceal the nature of the child's epileptic condition. As a result the child may labor under the belief that what he has is shameful and a disgrace to his family. The parents may refrain from correcting or punishing the child, having experienced that emotional tension precipitates a seizure: the relationship between childhood discipline and later (internalized) self-control is well known. Repeated visits to the physician, daily pill-taking, and exaggerated conformity to schedules tend to point up to the child his own differences.

A particular problem exists in necessary restriction in the child's play activities, such as swimming, bicycling, and climbing. In their anxiety over the child's safety, parents often curtail his activities more than necessary, so that he has insufficient opportunity for the maturing influences of play and work.

The child with epilepsy, as well as the adult, faces many stress-provoking situations, the most important of which, at any age, is the social rejection that comes with the label epilepsy, regardless of its form or cause. (Post-traumatic epilepsy, because it is more readily understood, may be socially more acceptable to the afflicted person and to his associates.)

Negative social attitudes and views may affect the personality in another way. The epileptic may share public misconceptions, negative attitudes, and fears about his illness. The author and H. H. Remmers<sup>40</sup> have told of one patient who revealed in filling out the *Handicap Problems Inventory* that he feared an early death. When informed that epilepsy rarely causes death, a long-standing fear was removed. The epileptic needs to obtain factual information for relief of anxiety about his disorder. To serve this need, the author has written a series of pamphlets for lay reading on various aspects of epilepsy. These have been published by the National Epilepsy League<sup>16</sup> as a special pamphlet issue of its newspaper *Horizon*, which is available without charge. Other publications suitable for use in bibliotherapy with the epileptic (and parents) are by Lennox,<sup>21</sup> Putnam,<sup>27</sup> Yahraes,<sup>41</sup> and the U.S. Children's Bureau.<sup>34</sup>

The matter of heredity is often of undue concern to the epileptic, a source of guilt to his parents, and unwarranted stigma upon the entire family. The role of genetics has been unduly emphasized. Lennox's studies<sup>19, 20</sup> indicated that an epileptic with a normal spouse would, on the average, have one chance out of 40 of having an epileptic child, while when both parents are normal the chance is believed to be 1 in 200.<sup>25</sup> Cases of epilepsy in which genetic factors predominate actually have a more favorable prognosis, with better responsiveness to treatment, fewer seizures, and fewer behavioral abnormalities.

### Discrimination

Epileptics are beset by discrimination at every turn. Regardless of the limitations imposed by seizures, the label epilepsy creates hardships in education, vocation, personal and social relationships, and even legally in many states.

Years ago when epilepsy was not treatable as it is today, laws were enacted that set those with the disease apart. Unfortunately legal discrimination remains on the statutes of many states and the federal government. In 1956 Barrow and Fabing<sup>3</sup> described these statutes and pleaded for legal reform. Fabing<sup>6</sup> recently reported little indication of improvement in laws affecting epileptics: 17 states still call for their sterilization, and 10 states deny epileptics the right to marry. The United States bars admission of epileptics (without brain damage), even for purposes of medical treatment. Only one state covers epilepsy in workmen's compensation second-injury funds.

Many states categorically forbid driving to anyone who ever had a seizure, including those who become seizure-free. Such antiquated statutes fail to recognize the differences among the epilepsies and the advancements in medical treatment. They legalize discrimination and force the epileptic underground.

Everywhere in the past and in many places of the world even today, there has been no adequate treatment to control seizures. Colonies were founded by governments and by philanthropic organizations for the care and education of epileptic children. Going to such institutions often became a commitment for life. We find these patients, now middle-aged, in our state hospitals unable to adjust to unsheltered living in society despite freedom from seizures.

Now with effective seizure control available, institutionalization of children because of epilepsy is no longer needed.<sup>24</sup> Through an intensive campaign, educators have been led to recognize epilepsy as no more complicated than any other problem of special education of exceptional children. With reasonable seizure-control, epileptic children are now integrated into the regular classroom. An occasional convulsive episode, handled in a calm, informed way by a classroom teacher, is a beneficial experience for other children and instills a humanistic, accepting attitude for them to carry into adulthood. When seizures are too frequent or other disabilities are present, the child may need the special educational facilities of his school. American schools do generally admit these children, and this is important progress. There still is the problem of social nonacceptance, especially among parents of normal classmates, but this is not solved by removing epileptic children from the scene.

Getting work is a discouraging task for the epileptic.<sup>15, 23</sup> Research has shown that properly placed epileptics are capable of normal work performance.<sup>33</sup> Yet, by operational policy, they are excluded from employment by a large majority of almost every kind of firm, more than any other major disability group, according to a recent study.<sup>8</sup>

The Introduction of a recent Veterans Administration<sup>35</sup> pamphlet states:

The degree of success achieved by VA rehabilitation personnel in vocational rehabilitation and placement of epileptic veterans probably is lower than that for any other major disability group. Other rehabilitation and employment placement agencies report similar experience. Most of the difficulty is due to the complexities involved, social rejection, restrictive legislation, misconceptions, and anxieties which have persisted and have caused rejection by industry.

It is not hard for the epileptic, whether his seizures are controlled or not, to manage to be hired, for his disability is not apparent even in a routine medical examination. However, when he has his first seizure on the job he is summarily discharged. Frequently this occurs on the first work day because the increased tension of a new

## ARTICLE OF THE MONTH

job and expected outcome may precipitate a seizure in even an otherwise well-controlled epileptic.

Although it is almost axiomatic that employers become more accepting with experience in employing the physically handicapped, this is not true in the instance of known epilepsy, since submarginal epileptic workers get past employment interviewers undetected and go from job to job spreading a bad reputation for all epileptics among employers. Capable epileptic workers with good seizure-control are ordinarily unknown to the employer.

### Employment and Vocational Rehabilitation

Certainly it is an undeniable fact that not all epileptics are employable in competitive industry. Their seizures may be too frequent and severe, they may have additional physical or mental disabilities, or they may be otherwise unprepared. With the greatest human sympathy for these people, we must recognize that they substantially increase the employment (job-getting) handicap of all people with epilepsy.

Many of this substandard work group could be helped to become capable workers. To obtain modern medical diagnosis and treatment for seizure-control is the first step. Also there is often a psychological problem that must be alleviated. The lack of work habits and job skills likewise is frequently a factor. These are problems the epileptic and those who help him must cope with before he enters the labor market. The small remainder of those who cannot be made employable require sheltered work or living arrangements.

Vocational rehabilitation specialists are not concerned with the well-controlled epileptic worker who passes for normal. They do not see him. It is only the one with a problem who applies for rehabilitation services.

A committee of the American Medical Association has been working on a work classification plan for the neuro-

logical diseases, including epilepsy. Through a systematic medical rating scale they hope that industry will be encouraged to hire capable epileptics by identification and screening of those not employable. In theory the plan is similar to the one developed many years ago for cardiac disability.

Dr. Edward Schwade,<sup>29</sup> a member of this AMA group, has proposed medical certification of degree of seizure-control for epileptics seeking work. This is patterned after his plan of medical certification for the issuance of driver's licenses to epileptics, now a proved success after several years of operation in Wisconsin.

To implement a scheme of identification and help for the problem epileptic, three action programs are needed. First, professional skills and facilities must be developed to achieve the medical, psychosocial, and vocational rehabilitation of those who can be helped. Second, arrangements must be provided for the care of the few who cannot be employed, arrangements satisfactory to those epileptics who now go from job to job, with all that implies in frustration and waste to themselves and employers and resulting curtailment of opportunity for others with epilepsy. Third, epilepsy must be made respectable through public education so that the normal person with epilepsy can come out of hiding. These three programs are interdependent and must progress simultaneously.

The role of the rehabilitationist is not only case evaluation and guidance that leads to appropriate individual solutions. In a broader sense the professionally responsible person must also join the fight to obtain acceptance and opportunity for all epileptics through the full force of his concern and knowledge of the epilepsy problem. As an interpreter he can close the information gap between the lay person and the scientist.

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## In Next Issue

The August issue of *Rehabilitation Literature* will feature as Article of the Month Part 1 of a two-part article, "Operational Technics for Sheltered Work Programs," by Miss N. P. Smith. The author has an extensive background in vocational services and workshops for the handicapped, as well as firsthand experience in the industrial field.

*Equipment for the Disabled; An Index of Aids and Ideas for the Disabled* will be the Review of the Month. The four-volume reference work was compiled by Margaret Agerholm, of the Nuffield Department of Orthopaedic Surgery, Oxford, and Elizabeth M. Hollings and Wanda M. Williams, both with the Nuffield Orthopaedic Centre, Oxford, and was published by the National Fund for Research into Poliomyelitis and Other Crippling Diseases, London, England. The reviewer is Muriel E. Zimmerman, consultant in self-help devices and homemaking with the Institute of Physical Medicine and Rehabilitation, New York.

## Review of the Month

# Understand Those Feelings

### A Guide for Parents of Handicapped Children And Everyone Who Counsels Them

by

Eugene T. McDonald, Ed.D.

Published by Stanwix House, Inc., 3020 Chartiers Ave.,  
Pittsburgh 4, Pa. 1961. 200 p. \$5.00.

Reviewed by Darrel J. Mase, Ph.D.

#### About the Author . . .

Dr. McDonald has been director of the Speech and Hearing Clinic, Pennsylvania State University, since 1946. It was at this University that he received his Ed.D. degree in 1942. Dr. McDonald is a fellow of the American Psychological Association and of the American Speech and Hearing Association, holding an advanced clinical certificate in speech. He is past president of the American Association for Cleft Palate Rehabilitation and of the Pennsylvania Speech Association. He is the author of many articles and books in speech.

#### About the Reviewer . . .

Dr. Mase earned his Ph.D. degree at Columbia University, New York City, in 1945. He has an extensive background in the speech arts and speech correction in public schools and colleges. Dr. Mase has been, since 1958, dean, College of Health Related Services, J. Hillis Miller Health Center, of the University of Florida, Gainesville. He is a fellow of the American Speech and Hearing Association and of the American Association on Mental Deficiency and is a member of the American Psychological Association and the Council for Exceptional Children.

MOST OF THE LITERATURE relating to handicapped children has been written by professionals and relates to diagnosis, treatment, and the feelings of those with disabilities. This book is written by the parents of handicapped children as interpreted through the eyes, ears, and heart of the author. Dr. McDonald, a psychologist and speech pathologist, has had a unique opportunity to counsel with many parents in the speech and hearing clinic that he directs and through the many programs for those with severe disabilities to which he relates as a consultant.

Approximately one half the content of this excellent publication presents actual discussions by parents in individual and group counseling sessions with the author. Dr. McDonald uses these and other counseling experiences to interpret the feelings of parents and to offer basic considerations in understanding their feelings. In the preface the author states: "1. Many problems are shared by all parents with handicapped children, regardless of the type of handicap. 2. Most of these problems have their origin in natural, everyday reactions that become serious only when misunderstood and misdirected. 3. Unless feelings are understood and properly directed, handicapped families tend to develop around handicapped children. 4. Most parents can work through their own problems if given proper guidance." When parents have an opportunity to express their feelings to a quiet, unhurried, understanding listener, he will find a basis for the embarrassments, hostilities, worries, doubts, and other troubled feelings so often exhibited. It is the point of view of the author that proper guidance, accurate information, a good rehabilitation program, and time will provide families peace of mind and a healthy attitude toward their children with disabilities. Only then can parents help these children to grow up to be as productive to themselves and to society as it is within their capacity to become.

The feelings of parents of handicapped children are not basically

different from those of parents of nonhandicapped children. All parents worry about their children's development, ability, and social acceptability and about a secure place in the world for them. The difference is one of degree. Many developmental and behavior patterns of children with disabilities relate to their being children. However, parents may see these patterns as relating to the disability rather than as a part of the growing-up process, which may be aggravated by the disability. The author suggests that we think of a handicapped family rather than a handicapped child. People are largely products of their environment. We should then treat the family as well as the child in order to improve the environment and thereby improve the productivity of the handicapped child.

One of the first things with which families need help is understanding their feelings in the interval between being told or discovering something is wrong with their child and finding what course of action can be followed. This is a period of many unanswered questions and parents become confused. Chronic confusion interferes with one's effectiveness. "Unrecognized and unmanaged feelings of confusion can lead to deeper feelings of insecurity and anxiety."

There are many other feelings with which parents will receive help and sound counsel by reading this book. The disappointment in having a handicapped child and how this may adversely affect the relationship of the parents to the child receive careful consideration. Parents are concerned about what others think when they discover they have a child with a disability. People are generally more willing to accept differences than we give them credit for. Parents may be reading things into their interpersonal relationships that are not justified. They need to try to see things from the viewpoint of those who do not seem to understand. The difficulty may lie with the parents.

Along with this concern of what others feel about those with handicaps and their parents is the matter of embarrassment. Embarrassment is a natural consequence when attention is focused on us, whether it be favorable or unfavorable attention. Physiological changes take place and we blush, experience a dryness of the mouth, or exhibit a feeling of nervousness in some other way. This natural reaction to embarrassment can become quite complex and can lead into feelings of anger and hostility. When these feelings are not recognized and not understood, they may influence relationships with teachers and other professional workers. All parents have been embarrassed by their children's behavior at one time or another. It is then not unusual for parents of children with handicaps to experience embarrassment.

**O**ne of the best chapters in the book is entitled, "Who Is to Blame?" This is a question that often goes unanswered in spite of the many attempts of parents. Man

has always been actively engaged in trying to explain why things are as they are, and he tries to do this in relation to his experience, using whatever information is available. Parents of the handicapped child may have very little information and may have resolved the matter by deciding upon some causation that may or may not have justification. Since they often do not have scientific explanations available to them, they very often end up with unscientific information as the basis for the causation. One mother stated, "When we don't understand what causes something it is natural to think that there is a supernatural reason for it." Parents generally blame themselves, God, and doctors for their child's handicap. They fail to recognize that even today, with all our research and scientific knowledge, it is often quite impossible to determine exactly what caused a child's handicap. This information would in many instances not change medical, therapeutic, and educational programs. It is better for parents to think in terms of "what might have caused it" rather than "who is to blame." Professional people should be able to help with the former but will seldom be able to contribute to the latter.

**O**ther basic problems of parents of children with handicaps considered by the author include the following: 1) parental worry about the future of their children, 2) the need of both parents' agreeing upon a course of action and maintaining a healthy home environment in carrying out the program, and 3) the recognition that some parents want to turn their problems over to God, while others denounce God because they have a handicapped child. Dr. McDonald's broad experience in counseling with parents leads him to the conclusion that parents who pray for help and understanding in accepting their children with handicaps seem to relate better to the counsel and advice of professional people and seem to accept the child with a disability and to provide better programs than those who do not have divine guidance. This topic is carefully and well treated.

The author offers a positive action program for the community. He encourages a closer understanding between parents and professional people and offers sound logic for some of the hostilities expressed by both. He explains why community programs must be developed to meet the needs of all handicapped children and that the goals must be realistic. He asks for a harnessing of the resources of the community toward attainable goals. He emphasizes that, even though parents understand their feelings and communities provide more comprehensive programs, these will not solve all the problems. However, these things will help parents "to learn to live more effectively with them."

*Understand Those Feelings* is a book that should be placed on the required reading list of students in training as physicians, clinical psychologists, speech pathologists,

## BOOK REVIEWS

audiologists, physical therapists, occupational therapists, social workers, nurses, teachers of exceptional children, and other professional personnel who will be working with children and disabilities. Students of the health professions will relate better to parents as they have experienced this accounting of parental feelings.

*Understand Those Feelings* is written that parents of handicapped children can see themselves as they read the book. They will find answers in some instances and explanations for their feelings in many others. This book is written and organized in such a manner that it can be used as a guide for discussion meetings. In many of the meetings of parents' groups, the parents' thinking is directed from their own feelings and problems to those of fund raising, social events, securing staff for programs, and other such details. This book could be

used as a focal point for the discussion of their attitudes with a different topic each month for a year's meetings. This should help parents understand the nature, genesis, development, and management of their feelings. This should contribute to improved mental health on the part of the parents, which will provide an improved environment for their children with handicaps.

Dr. McDonald has expressed the feelings of parents of handicapped children in a very straightforward manner but in such a way that no parent should take offense at these personal revelations. Twenty years of counseling with parents of handicapped children and all he has learned from parents in this period are shared with the reader. Parents and professional personnel will be able to relate more effectively to the needs of children with handicaps after reading this book.

### For Your Leisure-Time, Professional Reading

DOUGLAS RITCHIE was a well-known BBC commentator when, May 7, 1955, at the age of 50, he suffered a stroke that left him paralyzed on the right side and, worse, seriously aphasic. The account of his 3 years of recovery, which he subtitled *A Diary of an Aphasic*, was begun as a daily writing exercise at the suggestion of his speech therapist. American readers will note with interest his correspondence with his friend Clifton Utley, from whom he sought advice. Mr. Utley had had his stroke 2 years before Ritchie had his. (For an account of Utley's own courage and tenacity against the effects of his stroke, see *Today's Health*, Feb., 1959.)

#### Stroke; A Study of Recovery

By: Douglas Ritchie

1961. 192 p. Doubleday & Company, 575 Madison Ave., New York 22, N.Y. \$3.50.

It is apparent that the process of rehabilitation to such a patient as Mr. Ritchie entails much misery and unhappiness. He regards himself as an introvert—conceited, yet humble—and explains that his study is a subjective one. In a closing chapter he apologizes for being beastly to one of the nurses at the nursing home to which he was first taken and he credits the physiotherapist there for giving good advice that he ignored, and to her he apologizes for silently swearing at her. He has but the highest praise for the director and therapy staff of the Medical Rehabilitation Centre, Hampton Road, London, where he spent each day, 9:15 A.M. to 4:45 P.M. In his book he

describes the strange world he found there, which became familiar only after daily association for 18 months with the therapists and patients.

Mr. Ritchie credits his speech therapist for his success in language re-education, but, even more, for the emotional support he so badly needed. By appealing to his pride she encouraged him to undertake the long trip to the Centre alone by subway and bus, still speechless except for a few words. In fact he learned that, motivated by fear, he spoke better with strangers than he did with his own wife and friends. It took 8 months at the Centre before he found hope and noted progress in his treatment—only when he learned to have confidence in himself. At the same time his resentment against the doctors and therapists left him, after he no longer expected a miracle from them. He found within himself a new stability, based on a *mental tempo* slower than that before the stroke and a *physical tempo* faster than that when he first became ill.

We are pleased to note in the April, 1961, issue of *Physiotherapy* that Mr. Ritchie participated in a Conference on Stroke Rehabilitation held June 22 in The Livery Hall, Guildhall, London. At this Conference, sponsored by the Chest and Heart Association, Mr. Ritchie presented the point of view of the stroke patient. And ably, too, we are sure. We should like to bring to the attention of Mr. Ritchie and to the readers of our review the report on hemiplegic patients treated at the Medical Rehabilitation Centre, as submitted by Mr. Sommerville of the Centre's staff in a letter to the editor of the *British Medical Journal*, April 1, 1961. This report will be found on page 228 of this issue of *Rehab. Lit.*—The Editor

## Other Books Reviewed

498

## Classics in Psychology

Edited by: Thorne Shipley

1961. 1342 p. Philosophical Library, Inc., 15 E. 40th St., New York 16, N.Y. \$20.00.

**CONTENTS:** Psychology as a science, newly founded upon experience, metaphysics and mathematics, Johann Friedrich Herbart.—Contributions to the theory of sensory perception, Wilhelm Wundt.—Treatise on physiological optics, Hermann von Helmholtz.—The analysis of sensations and the relation of the physical to the psychical, Ernst Mach.—Principles of psychology, William James.—The postulates of a structural psychology, Edward B. Titchener.—General psychology from the personalistic standpoint, William Stern.—*II. Psychopathology*: Treatise on insanity, Philippe Pinel.—Mental maladies: A treatise on insanity, (Jean) Etienne Dominique Esquirol.—Clinical lectures on certain diseases of the nervous system, Jean Martin Charcot.—Dementia praecox or the group of schizophrenias, (Paul) Eugen Bleuler.—Lectures on clinical psychiatry, Emil Kraepelin.—Medical inquiries and observations, upon the diseases of the mind, Benjamin Rush.—The dissociation of a personality, Morton Prince.—*III. Organic Therapy*: The effect of malaria on progressive paralysis, Julius Wagner von Jauregg.—The pharmacological shock treatment of schizophrenia, Manfred Sakel.—*IV. Neurology*: On affections of speech from disease of the brain, (John) Hughlings Jackson.—The integrative action of the nervous system, Sir Charles Scott Sherrington.—*V. Psychoanalysis*: Studies on hysteria, Josef Breuer and Sigmund Freud.—The practice and theory of individual psychology, Alfred Adler.—Two essays in analytical psychology, C. G. Jung.—*VI. Behavior Theory*: Conditioned reflexes; an investigation of the physiological activity of the cerebral cortex, Ivan Petrovich Pavlov.—Psychology as the behaviorist views it, John B. Watson.—Mind, mechanism, and adaptive behavior, Clark L. Hull.—*VII. Individual Differences*: Mental tests and measurements, James McK. Cattell.—The development of intelligence in children, Alfred Binet and Theodore Simon.—Psychodiagnostics; a diagnostic test based on perception, Hermann Rorschach.—*VIII. Child Psychology*: Wayward youth, August Aichhorn.—Adolescence; its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion, and education, G. Stanley Hall.—The language and thought of the child, Jean

Piaget.—*IX. Gestalt Psychology*: Experimental studies on the seeing of motion, Max Wertheimer.—The mentality of apes, Wolfgang Köhler.—Perception; an introduction to the Gestalt-Theorie, Kurt Koffka.—*X. Social Psychology*: A treatise on the medical jurisprudence of insanity, Issac Ray.—Intention, will and need, Kurt Lewin.—An introduction to social psychology, William McDougall.

499

Evaluation of Drug Therapy; Proceedings of the Symposium on Evaluation of Drug Therapy in Neurologic and Sensory Diseases . . . University of Wisconsin, May, 1960

Edited by: Francis M. Forster

1961. 167 p. University of Wisconsin Press, 430 Sterling Court, Madison 6, Wis. \$4.00.

SPONSORED BY A GRANT from the National Institute of Neurological Diseases and Blindness, this symposium had as its aim the development of greater co-operation among persons of various professions and agencies involved in developing and evaluating drugs. Pharmacologic aspects of testing were discussed by a pharmacologist, a representative of the pharmaceutical industry, and an official of the U.S. Food and Drug Administration. Clinical problems in planning and conducting drug evaluation trials were discussed by biostatisticians, following which the approximately 100 scientists divided into 8 panel groups to consider and draw up concise statements of acceptable methodology for drug testing in relation to specific sensory and neurological diseases. Panel reports covered epilepsy, vertigo, neuralgias and neuropathies, headache, glaucoma, multiple sclerosis, diseases of the muscles, parkinsonism, and diseases of the basal ganglia. The need for uniformity of criteria in diagnosis and criteria for improvement was emphasized throughout the discussions.

500

Frontiers of Elementary Education, VII; Papers Presented at the Seventh Annual Conference on Elementary Education, School of Education and Division of the Summer Sessions, Syracuse University, 1960

Compiled and edited by: Vincent J. Glennon

## BOOK REVIEWS

1961. 78 p. Paperbound. Syracuse University Press, Box 87, University Station, Syracuse, N.Y. \$1.75.

SEVENTH OF A SERIES of reports of annual summer conferences held at Syracuse University to explore various approaches to educational problems at the elementary level, this collection of papers covers a wide range of topics. Divergent views on new methods of teaching arithmetic and mathematics, a radically new plan for elementary school organization, a criticism of contemporary education, and two papers on teaching the emotionally disturbed, socially maladjusted child and reading characteristics of mentally retarded children, contributed by Carol Cordes Smith and Lloyd M. Dunn, respectively, are included.

501

**Gehschule für Beinamputierte; Ein Handbuch für Beinamputierte, Fachärzte für Orthopädie, Orthopädie-mechaniker, Krankengymnastinnen und Übungsleiter im Versehrtensport**

By: Herbert Kersten (with a section by Günter Brumm, M.D.)

1961. 195 p. illus., figs. Paperbound. Published by Georg Thieme Verlag, Herdweg 63, Stuttgart N., Germany, and available in the U.S. and Canada from Intercontinental Medical Book Corp., New York 16, N.Y. \$4.75.

A TEACHER of amputee gait training who is himself an amputee discusses in detail the general principles of training and the specific technics used in his training school. Special chapters are included on rhythmic gait training and the problems of patients with hip disarticulation or double amputations. The use of exercises, games, and sports in training is explained; the many illustrations and diagrams give additional value to the book. A valuable inclusion is Dr. Günter Brumm's publication, "Maintenance and rehabilitation of functioning of leg stumps from the viewpoint of the gait training school" (p. 161-190), written in a style that can be understood by the amputee.

502

**A Guide to Comprehensive Rehabilitation Services to the Homebound Patient (A Textbook)**

Sponsored by: National Association of Sheltered Workshops and Homebound Programs (Janet I. Pinner and M. Roberta Townsend, Co-ordinators; Reva S. Tickton, Editor)

1961. 136 p. Paperbound. (*Monograph no. 4, April, 1961*) Copies are available from U.S. Dept. of Health, Education, and Welfare, Washington 25, D.C.

UNDER A GRANT from the U.S. Office of Vocational Rehabilitation, 17 persons associated with service programs for the homebound co-operated in a writing seminar that resulted in this textbook. The contents provide practical, applicable information for those wishing to establish homebound services of the type usually found in the comprehensive rehabilitation center. Discussion of services is grouped under the subjects: medical, counseling, educational, employment, and constructive nonremunerative activities. In addition is a brief discussion of independent living rehabilitation, identifying it as an important factor in the future development of services. Also outlined are basic steps in establishing a program of services for the homebound. Descriptions of five current programs offering rehabilitation services for the homebound illustrate the organization and administration of industrial homework, prevocational evaluation, homecraft program, and a craftsmen shop to merchandise handmade products of older persons.

This book should help to identify the problems of the homebound and the areas of rehabilitation service that could and should be made available to them, and to encourage further research in long-overdue programs for a growing group of the disabled.

503

**Guide to Employment of Disabled Persons; Results of the Survey of Employment Opportunities for the Handicapped in Regina, Saskatchewan**

By: Co-ordinating Council on Rehabilitation (Saskatchewan) (G. Allan Roeher, Ph.D., Project Director)

1961. (71) p. tabs., forms. Mimeo. Published by the Co-ordinating Council on Rehabilitation (Saskatchewan), 416 Health and Welfare Bldg., Regina, Sask., Canada. A limited number of copies are available from Dr. G. Allan Roeher at the above address.

FINDINGS OF A SURVEY in Regina, Canada, to obtain pertinent information on employment conditions that would be of practical help in program planning, curriculum development, counseling, and placement of handicapped persons in employment have been compiled in this manual designed to aid the counselor, teacher, and placement officer. Specifically, the survey attempted to determine occupations suitable for and open to persons with physical or mental handicaps, the physical demands and work conditions of such occupations, and the kinds of work available for subcontract to sheltered workshops and work-conditioning units. A secondary objective was the gathering of general information on employers' personnel policies and promotional systems as they affect the disabled and types of jobs currently held by the disabled. Survey methods are described and the findings analyzed.

Data include information on physical demands of the jobs listed, the academic and vocational requirements, and analyses of working conditions in the various types of employment. Discussions of employer attitudes and their experience with handicapped employees are of interest.

504

**The Healing Heart**

By: John Carlova, with Ora Ruggles

1961. 256 p. Julian Messner, Inc., 8 W. 40th St., New York 18, N.Y. \$3.95.

IN 1918 WHEN wounded American soldiers were returning from European battlefields, occupational therapy was not an officially recognized profession. Ora Ruggles, recruited as a "reconstruction aide" to work at the Army Rehabilitation Center, Ft. McPherson, Ga., had the monumental task of overcoming military and medical opposition to her efforts. Her success with the war wounded led to a lifelong career in occupational therapy, in military hospitals, in private sanatoriums, and finally in Children's Hospital of Los Angeles, where she started an occupational therapy department that offered training to volunteers. Considered a pioneer in the profession she helped to found and develop, Ora Ruggles exemplifies the dedicated therapist who contributes so much to rehabilitation. Dramatic as fiction, her life story should interest young people in the rewards of occupational therapy as a career.

505

**Health Organizations of the United States and Canada, National, Regional, and State: A Directory of Voluntary Associations, Professional Societies and Other Groups Concerned with Health and Related Fields**

Compiled by: Graduate School of Business and Public Administration, Cornell University (Clara Sedacca Wasserman, with Paul Wasserman)

1961. 191 p. (Lithoprinted by Edwards Bros., Ann Arbor, Mich.) Available from Publications Section, Graduate School of Business and Public Administration, Cornell University, Ithaca, N.Y. \$10.00.

THIS DIRECTORY of unofficial national, regional, and statewide organizations in health and related fields should fill a long-felt need for a complete listing in one volume of such information. From information supplied in most cases by the organizations themselves, the editors have summarized details on location, names of principal officials, purposes and objectives, finances, programs and activities, publications, prizes and awards, meeting dates, and organizations' affiliates. The three sections of the directory list: 1) national and regional organizations of

the United States and Canada; 2) statewide organizations, with summary information only on independent groups not affiliated with national organizations; and 3) national and regional organizations classified under each subject related to their activities and purposes.

506

**Rehabilitation and World Peace; Proceedings of the Eighth World Congress of the International Society for the Welfare of Cripples . . . New York, August 28-September 2, 1960**

Edited by: Eugene J. Taylor

1961. 433 p. Paperbound. International Society for Rehabilitation of the Disabled, 701 First Ave., New York 17, N.Y. \$1.00.

THE EIGHTH WORLD CONGRESS of the International Society for the Welfare of Cripples (now the International Society for Rehabilitation of the Disabled) was the first of its kind to be held in the Western Hemisphere. Approximately 3,000 persons from more than 70 countries participated in the week-long meeting of general and special sessions. Lectures and special papers submitted by eminent rehabilitation specialists of many countries are included in the proceedings; their subjects covered many aspects of work in the rehabilitation field—employment, special education, unmet needs in various countries, the use of volunteer workers, and the role and responsibilities of national voluntary rehabilitation agencies. Selected Congress papers, not included in the proceedings, have appeared in recent journals (for examples, see *Rehab. Lit.*, Dec., 1960, p. 378; Apr., 1961, #299; May, 1961, #386; July, 1961, #522).

507

**Tender Tyrant; The Story of a Mentally Retarded Child**

By: Carvel Lee

1961. 180 p. Augsburg Publishing House, 425 S. Fourth St., Minneapolis 15, Minn. \$3.00.

THE YOUNGEST CHILD in a large family of healthy, happy, intelligent children, Jeanie aroused all their love and protective instinct. She was to need such care all through her life, for Jeanie was mentally retarded. Mrs. Lee, as the sister three years older than Jeanie, recognized the child's limitations while still a youngster herself and vowed to help her all she could. The story of family life during Jeanie's childhood and adolescence and her eventual institutionalization reveal all the heartaches and rewards of accepting the mentally retarded child for what she is while realizing that life can never be the same for children such as these.

## Digests of the Month

*Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.*

508

### Reading for Handicapped Children (Lasning for Handikappade Barn)

By: Olle Wingborg (*Librarian, Stadsbiblioteket, Norrtälje, Sweden*). Translated from the Swedish by Alma Lundeen (*Institutional Consultant, Illinois State Library*)

In: *Illinois Libraries*. Apr., 1961. 43:4:235-241. (Article originally appeared in: *Biblioteksbladet*. Sept., 1960. 45:7:584-586.)

**I**N OREBRO COUNTY a recent survey of the care needs of children disclosed 7.2 per thousand in need of long-time care. The largest group, 4.8 per thousand were mentally retarded, .8 per thousand were deaf, .3 per thousand blind, and .1 per thousand epileptic. The remainder were physically disabled and other groups. Similar conditions may be expected in other counties. The community is beginning to realize its responsibility for the handicapped, long sadly neglected.

All handicapped children run the risk of becoming isolated, depending on psychical and physical factors. Libraries have a duty to break this isolation for both old and young. Mental isolation during the growing years may keep the adult from his place in the community. Without books, the handicapped person misses much that is life-enriching and compensating. Very little has been written on this matter, although there are general professional books on the subject. One is *The Handicapped Child* by Edith M. Stern, with Elsa Castendyck [A. A. Wyn, Inc., New York, 1950], an elementary but reliable book that can be recommended.

What kind of book should the handicapped read? A child does not have to read special books because he is bedfast or confined to a wheel chair. Carefully selected, easily read books, however, are needed for the mentally retarded and the deaf. Free reading will aid special schools and prescribed school forms for the retarded to give their pupils the training and knowledge they need for independence after leaving school.

Congenital deafness is more handicapping than people realize. The deaf are not naturally retarded, although a person may have both handicaps. However, shut off from all spoken stimulation, the deaf are limited in comprehension. Those able to master the regular school program are few; the majority make little progress intellectually because of their language lack. The deaf have the same

needs as others, and it seems strange that librarians have given them no attention.

**B**ooks for the mentally retarded and the deaf should have simple language and distinct and clear typography and be richly illustrated. Contents should entice the reader in spite of all the difficulties met. Material should be handled concretely; preferably the milieu should be familiar. Simple, everyday stories are more easily comprehended than double-barreled fantasies or frolicsome stories such as the Pippi Longstocking stories by Astrid Ericsson Lindgren. Special school pupils can benefit from the usual boy and girl stories, as can deaf children to some extent. A good many deaf who present no book selection problems do learn to read the general run of books.

The deaf, especially, need more books of the recognition and picture type, to become familiar with commonplace objects and concepts. For the youngest in the special schools and schools for the deaf, there are excellent primary books with illustrations and text designed to make learning as easy and enticing as possible. With older pupils, the youngest children's books have a good level of difficulty, but they are no longer satisfied with fairy tales and little children's stories. Their interests often are those of normal children their age. It is difficult to find suitable books, although it is in the higher groups that these pupils attain reading skills. Photographic picture books and special subject supplementary material on the elementary level often serve the purpose, such as Astrid Suckdorff's *Chendru: The Boy and the Tiger* (Harcourt, Brace and Co., Inc., 1960).

Some books are especially prepared for the deaf and others are listed for special school students. The school library consultant compiled a list of books recommended by special school librarians, and I have been commissioned by Bibliotekstjanst to indicate in the catalog *Barnens Böcker* (*Children's Books*) those suitable for special school pupils. I propose that Bibliotekstjanst apply these principles always in their book selection lists, not only for special schools and schools for the deaf, but for "help" classes and classes for normal children with reading difficulties. Bases of selection are largely similar for all these groups even though reading levels differ. The deaf and mentally retarded could benefit from books adapted for other groups. Judgment and discretion are needed in using the lists. Other books should be supplemental. Foreign children in the industrial centers could

be helped by the books listed. For the partially sighted, books with large type should be given.

Radio and talking books have helped the blind, but they should not displace embossed books for children of school age. Raised type requires over three times as much space or volumes than embossed do. Special reading aids are needed by many disabled and bedfast, such as reading apparatus and page turners. Books used by invalids and the mentally retarded, who often have motor difficulties, should be strongly bound to withstand extra wear.

In many places communal libraries and special schools co-operate, and lectures have been arranged for special school personnel on book and library problems. Numerous homes and schools remain unaware of what libraries can contribute and of what state funds are available or they discourage borrowers with old books in dreary covers. The central library has a large mission to fill—co-operating with the school library consultant and library service to disseminate information and supply traveling libraries, which would result in the formation of local libraries. If one could contact everyone listed in the *Swedish Social Care League Directory* and tell him how to obtain books, loneliness would be dispelled for many.

A survey of cerebral palsied children who left the Eugenia Home during 1954-1955 revealed that only 28 of 159 students worked away from home. This is just one example of how contact with the world is lost after leaving school. Books could add meaning to life and fill idle hours. In Ludvika and Malmo, where home library service began, scouts visited the sick and aged to take books to them. This type of service should become general, with no distinction between young and old. District nurses, district visitors, clergy, doctors, and social welfare services should give direction, so that as many as possible of those who would welcome "book visits" are reached. Libraries should contact such organizations as "handicapped scouting" and federations of persons of various disabilities. With publicity by them the handicapped would make themselves known. Book collections might be taken to meetings of such groups.

Scouts, church brethren, Rotarians—and why not Friends of the Library—are willing helpers and could be patrons with home visitors assigned to them as part of a program. Even a simple program, serving only a few, means a great deal. Borrowers all know that a telephone call to the library brings services if they are ill, and such limited service has created good will. I hope that library service to the sick and handicapped will become just as matter of course as interlibrary loans.

*Illinois Libraries* is published monthly (July and August excepted) by the Illinois State Library, Springfield, Ill. For a listing of other articles in the April, 1961, issue on library services to the handicapped, see #544, this issue of *Rehab. Lit.*

509

### Comprehensive Prosthetic Care (Chapter 3)

In: *Sixth Annual Report, 1960, Child Amputee Prosthetics Project*, Ch. 3, p. 15-24. Wilma Gurney, Editor.

1961. 62 p. Mimeo. Illus. Dept. of Pediatrics, School of Medicine, University of California at Los Angeles, Los Angeles, Calif.

**C**OMPREHENSIVE PROSTHETIC CARE is: using all resources of the child, his family, our Project, and the community to aid the child amputee meet his needs while growing up to enjoy the pleasures and responsibilities of adult life. Work with the child and family must begin immediately, even though prosthetic fitting must be later on. In either a newborn or new surgical amputation, those involved should know they are not alone and someone understands the problem so frightening to them. Physicians and professional advisers in a regular practice cannot give adequate counsel. We at the Child Amputee Prosthetics Project (CAPP) have studied, examined, and interpreted the responses and reactions of people in such crisis and then studied ways to meet their needs. We now see parents and their newborn before they leave the hospital instead of when babies are 10 days to a few weeks old.

Preparing a family for a prosthetics program gives them opportunity to learn responsibilities in the program, while they learn of the staff and each member's part in meeting the child's needs. They can observe the competence and feel the interest in them as people. The staff knows something of them from the referral source and through the Project medical director's communication with the child's physician. On the initial visit the family sees the social worker, who helps them understand the program. With her they can release their feelings about the difference in their child. Often for the first time they recognize the ramifications and view the mechanical substitute for the missing or ineffective limb as an actuality. The social worker breaks ground for the building of a sound prosthetics program. The interview focuses on the child's needs, often in contrast with the parents' needs.

The social worker introduces the family to an occupational or physical therapist, who discusses how the child learns to use a prosthesis and the training sequence. The parents (and child) consider an actual device. That the child will wear one becomes unescapably real. Parents wishing for a life-like substitute may find it almost impossible to listen to mechanics of a training program while reacting to the reality of the device. The therapist demonstrates her acceptance of them as people and of the child. Engaging the child in activities permits her to observe how the parents accept their child. Some are too protective, others have allowed the child to be unmanageable. Time is devoted to his functional needs and the manner in which a prosthesis can help.

## DIGESTS

The therapist takes the family to the prosthetist, who discusses the best device for the child. Often he is confronted with disbelief, particularly if relatives and friends have assured them that medical science has produced body parts almost better than the real thing. These parents now doubt the knowledge and authority of CAPP. Expectation of a miracle poses problems for the whole staff. The prosthetist understands the impact on the parents and through confidence in his colleagues can usually help the parents become more realistic.

The medical director, after a staff conference, meets the parents and discusses areas best handled by him. In his pediatric examination he conveys his interest in the child's total development. He obtains what prenatal and family history he can at this point and clarifies the program. He tells them they will see the orthopedist the next day but do not have to decide at that time, for the staff knows that for the prosthesis to be effective the parents must support their decision.

Before seeing the parents the next day, the clinic team discusses findings and impressions and the orthopedist weighs his findings on a prosthesis with those of the staff. Realistic goals and the family's capacity for the program are discussed. If a prosthesis is desired, types are reviewed and a selection made. The timing of fittings is set up, based on family circumstances, previous experience, and present work load. Carefully thought-through planning, shared with parents, can produce results beyond that thought possible.

Early contact and support through visits before a prosthesis is used can avoid failure. The infant with arm involvements is usually fitted at the stage of trying to sit alone. Attempts to pull to a standing position are the best indicators for applying lower extremity prostheses. Early application takes advantage of the child's play. Early play becomes play-work, and tasks and skills build on simpler tasks and skills. A child who loses a limb because of accident or disease must be fitted as soon as medically permissible to avoid irreparable physical and psychological regression.

CAPP prosthetists make and maintain prostheses having experimental parts or fabricated in unusual ways at no cost to parents or Crippled Children's Services (CCS). Standard prostheses are made and maintained by convenient certified limb shops and are paid for by CCS units or families when able. All prostheses are prescribed with two cables and two harnesses, to allow for repair and laundering. Local prosthetists aid in research by reporting every adjustment and repair made to their prostheses.

Some children use a standard prosthesis as a spare when an experimental one usually worn is modified or repaired. Such children are chosen because of his and his family's ability to participate actively in the program.

The sequence in training that CAPP therapists follow

utilizes the natural learning patterns of children, incorporates toys and activities, and leads to more complex tasks. The initial period has 5 to 15 intensive sessions, dependent on the child's age and nature of the prosthesis. Parents and child learn to care for the prosthesis, remove and replace the harness or a damaged cable, and recognize signs of malfunction and discomfort requiring adjustment. Interesting activities help the child learn the controls.

All children receive continued training from therapists who work at near-by schools for the handicapped or are with the Elk's Mobile Units. Lectures, demonstrations, and workshops keep these therapists informed. They are contacted directly on specific patients. Frequency of local ongoing training depends on the child's age, the problem, and the capacity of child and parents to follow through. Therapists are notified of the time of Project review and evaluation (done once to three times a year) and send in a progress report. A clinic team reviews material sent in, works with the patient and/or parents, and recommends plans for the future.

The social worker talks with parents at least twice during the initial training, more often if needed. When going out with a new prosthesis, parents and the child test out with the social worker their reactions to questions and looks of others. In review and evaluation sessions, the social worker confers with those needing support. With acute problems, not always related to the prosthesis, parents are referred to a family casework type agency. An ongoing function of the social worker is helping parents use the local therapist, family physician, and school. She, often with the medical director, talks to groups of therapists, schools of nursing, public health units, physicians, and social workers on what amputation or malformed extremity means to the patient and family and how the "helping professions" can work effectively. Thus realistic teaching is brought to those most frequently the first to see and talk with parents.

The medical director keeps in close touch with the family's physician or clinic. He strengthens the family's ties with the physician while serving as a specialist with a profound interest in the child's growth and development. Patients are given complete medical work-ups annually and additional tests as needed. Two orthopedic surgeons work closely with the director in direct care of the patient and participate in research relating to classification of limb defects and surgical procedures. With the department of pediatrics, another orthopedist, consultants, and the staff study chromosome patterns of children with congenital limb deficiencies. The chief of the orthopedic department, the medical director, prosthetists, and engineers study prosthetic components and fabrication. All the staff use every opportunity to discuss the Project and its results with professional groups. Visual aids illustrate methods and responses.

## Abstracts of Current Literature

*This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

### AMPUTATION

See 501.

### AMPUTATION—EQUIPMENT

510. Strohm, Bernard R. (*Univ. of California School of Medicine, Los Angeles 24, Calif.*)

Patella tendon bearing-cuff suspension below-knee prosthesis; an evaluation procedure, by Bernard R. Strohm and Lorraine Ogg. *Phys. Therapy Rev.* May, 1961. 41:5: 339-343.

A description of a below-knee prosthesis developed at the Biomechanics Laboratory of the University of California (Berkeley and San Francisco) by the Prosthetics Research Group in 1958. Differences in construction and consequent differences in problems to be anticipated between the new prosthesis and the conventional type of below-knee prosthesis are discussed. A check-out procedure for evaluating the comfort, cosmesis, and function of the new prosthesis is included. Details of fabrication and gait training are omitted but references are supplied (see *Rehab. Lit.*, Dec., 1959, #891, and Mar., 1960, #139). Experience with more than 200 patients has proved the comfort and acceptability of the prosthesis; patients have also achieved more normal gait.

### AMPUTATION—EQUIPMENT—RESEARCH

511. *Artificial Limbs.* Apr., 1961. 6:1.

Issue devoted to articles on the Syme's amputation and Syme prostheses.

Contents: Syme's amputation, Walter Mercer.—The history and development of Syme's amputation, R. I. Harris.—Syme's amputation for gangrene from peripheral vascular disease, Gordon M. Dale.—Prostheses for Syme's amputation, A. Bennett Wilson, Jr.—The biomechanics of the Syme prosthesis, Charles W. Radcliffe.—The plastic Syme prosthesis in Canada, C. S. Boccius.—Some American experience with Syme prostheses, Herman Gladstone and Louis Iuliucci.

Articles cover detailed and accurate descriptions of the methods used in the operation; the biomechanics of the Syme prosthesis, particularly the locomotion pattern and the manner of weight bearing; and the actual prosthesis, with emphasis on the features of the current Syme prosthesis. This issue of *Artificial Limbs* should remain a classic contribution to the literature.

A publication of the Committee on Prosthetics Research and Development, it is distributed by the National Academy of Sciences-National Research Council, 2101 Constitution Ave., Washington 25, D.C.

### AMYOTONIA CONGENITA

512. Hardman, Robert (*4200 E. Ninth Ave., Denver 20, Colo.*)

The floppy infant. *Am. J. Diseases of Children.* Apr., 1961. 101:4:525-535.

Systemic disease, neurogenic causes, and myogenic causes responsible for producing the "floppy infant" syndrome are reviewed; only the most significant references in the literature are noted. Also discussed are clinical and laboratory aids in the differential diagnosis of the various conditions producing the syndrome. Although effective therapy is not available for many of these conditions, specific treatment in certain ones can result in improvement. Because of wide variation in prognosis, precise diagnosis of the cause of the syndrome is highly desirable. This is another of the seminar articles from the University of Colorado School of Medicine that have appeared in recent issues of the *Journal*, reviewing current knowledge in particular disease entities. 30 references.

### APHASIA—BIOGRAPHY

See p. 208.

### AUDIOMETRIC TESTS

513. Fisch, L. (*Miss Back, Centre for Spastic Children, Cheyne Walk, London, Eng.*)

The assessment of hearing in young cerebral palsied children, by L. Fisch and D. E. Back. *Cerebral Palsy Bul.* 1961. 3:2:145-156.

Regular weekly hearing testing and observation for all cerebral palsied children attending the Centre for Spastic Children, London, was begun in February, 1956; 76 children were tested between 1956 and 1958. The study attempted to assess the practical difficulties of testing children under 5 years of age and the time required to reach a final conclusion concerning their hearing. Methods of testing hearing in small cerebral palsied children are reviewed, with suggestions for overcoming various testing difficulties. Low mental ability and degree of physical handicap were the two most important factors influencing time required for full assessment. It is recommended that all cerebral palsied children should be routinely tested whether deafness is suspected or not.

### BLIND

514. Fonda, Gerald (*The Lighthouse, N.Y. Assn. for the Blind, 111 E. 59th St., New York 22, N.Y.*)

Definition and classification of blindness with respect to ability to use residual vision. *New Outlook for the Blind.* May, 1961. 55:5:169-172.

The medical director of the Low Vision Lens Service, The Lighthouse of New York, suggests further refinements in currently accepted definitions of blindness and four groupings that represent a more practical classifica-

## ABSTRACTS

tion of the partially seeing. The purpose of this classification scheme is to establish an arbitrary standard for the greatest use of residual vision; it should be helpful to the teacher or counselor in deciding educational methods for the child and type of training or employment most suitable for the individual. Ability to use residual vision cannot be determined solely on the basis of definition of blindness; other factors influence ability.

**515. Rodgers, Carl T.** (*Am. Found. for the Blind, 15 W. 16th St., New York 11, N.Y.*)

Some thoughts on white cane philosophy and problems, by Carl T. Rodgers and Arthur L. Voorhees. *New Outlook for the Blind*. May, 1961. 55:5:173-177.

Characteristics of "white cane" laws in the U. S., the concept of the white cane program, and the undesirable effects of the program and laws passed by the various states are considered. In the writers' opinion such laws serve no positive, constructive purpose and little if any functional purpose and only emphasize the stereotyped concept of the blind as helpless and generally incapable. An editorial on p. 181 suggests a re-evaluation of the degree of safety that can be achieved through use of the white cane.

### BLIND—MENTAL HYGIENE

**516. Thume, Lee** (*Arkansas Rehabilitation Service, Services for the Blind, 109 W. 12th St., Little Rock, Ark.*)

Acceptance of the white cane and hope for the restoration of sight in blind persons as an indicator of adjustment, by Lee Thume and Oddist D. Murphree. *J. Clinical Psych.* Apr., 1961. 17:2:208-209.

Results of a questionnaire study of 34 totally and 43 partially blind persons revealed a relation between 3 variables in adjustment: acceptance of the white cane, hope for eventual restoration of sight, and personality and vocational adjustment. Acceptance of the cane and loss of hope for return of sight are highly favorable indicators for adjustment. Among those providing rehabilitation services for the blind, a majority believe acceptance of blindness as a relatively permanent reality is necessary for any progress toward independence.

### BLIND—SPECIAL EDUCATION

**517. Jones, John Walker** (*U. S. Office of Education, Washington 25, D.C.*)

The blind child in school. *School Life*. Feb.-Mar., 1961. 43:6:7-10.

More and more blind and partially seeing children are receiving their education in local public schools; two new plans have been developed to supplement the full-time special class and residential school programs. A higher incidence of blindness among infants, difficulties of expanding residential school facilities, general trend of treating and educating handicapped children in their own communities, and the changing educational philosophy concerning classification of blindness in children are responsible for the growth of special programs for their education. Long-range planning is necessary, especially at the state level, to improve existing programs, to recruit personnel, and to aid administrators in providing equal educational opportunities for these children.

*See also 578.*

## BRAIN

**518. Goldstein, Robert** (*Jewish Hosp. of St. Louis, 216 S. Kingshighway Blvd., St. Louis 10, Mo.*)

Hearing and speech in follow-up of left hemispherectomy. *J. Speech and Hear. Disorders*. May, 1961. 26:2: 126-129.

Results of follow-up testing of a 42-year-old patient 6 years after undergoing hemispherectomy are compared with preoperative and 1 1/2-year postoperative test results. Speech and hearing were essentially normal and essentially unchanged from what they had been preoperatively and postoperatively. The only relevant auditory abnormality noted was poorer than average discrimination in the right ear for relatively difficult speech. Auditory sensitivity was considered normal.

## BRAIN INJURIES—PARENT EDUCATION

**519. Barsch, Ray H.** (*4356 N. Raymir St., Wauwatosa 16, Wis.*)

Counseling the parent of the brain-damaged child. *J. Rehab.* May-June, 1961. 27:3:26-27, 40-42.

As part of the evaluation, training, and counseling program for brain-injured children and their parents, developed by the Child Development Division of the Milwaukee Jewish Vocational Service, group discussions for mothers of children with organic brain damage have been held for the past 7 years. Administration of the program, its objectives, the role of the counselor, and the general principles taught parents are discussed here. Conclusions and recommendations on group counseling, based on this experience, are included. (See also *Rehab. Lit.*, Mar., 1961, #178, and Dec., 1960, #908.)

## CAMPING

**520. Woodward, Everett W.** (*Seattle Univ., Seattle 22, Wash.*)

Camping; motivation in communication skills for speech impaired children. *J. Health, Phys. Educ., Recreation*. May-June, 1961. 32:5:26-27.

In same issue: Camping; transition between hospital and home for the adult mentally ill, Sidney H. Acuff. p. 24-25, 62.

Speech and hearing therapy is provided for approximately 60 children each year in a special 16-day program at Washington State's Camp Coeur d'Alene. Both boys and girls, ages 9 to 14, whose speech and hearing problems are not complicated by other anomalies are included. All camp activity is planned around communication experiences. Speech and hearing therapists work with regular staff counselors and program directors. Camping activities and methods of administering the adapted program are discussed.

Mr. Acuff (*Eastern State Hosp., Knoxville, Tenn.*) describes an experimental camping program, considered an extension of the hospital's therapeutic treatment program, to prepare adult mental patients for discharge from the hospital. A sample of a normal day's activities and the advantages of camping as preparation for discharge are discussed. Camp staff is made up of hospital personnel—psychiatric aides, registered nurse, and adjunctive therapists.

## ABSTRACTS

### CEREBRAL PALSY

521. Rembolt, Raymond R. (*University Hospitals, State Univ. of Iowa, Iowa City, Iowa*)

Cerebral palsy; a challenge. *Am. J. Phys. Med.* Apr., 1961. 40:2:47-51.

In his presidential address at the 1960 annual meeting of the American Academy for Cerebral Palsy, Dr. Rembolt reviewed general accomplishments in the field of cerebral palsy over the past 10 years. Areas demanding greater emphasis in the future are: intensive research in prevention and management, methods to achieve favorable personality development in the cerebral palsied, and a revision of the philosophy of the "team approach" and its procedures. He suggests a seven-point plan for improving communication and co-ordination among team members and recommends parents be included as essential members of the care and treatment team.

### 522. World Commission on Cerebral Palsy

Papers presented at the Scientific Sessions of the . . . August 31, 1960 . . . New York City, as part of the Eighth World Congress of the International Society for Rehabilitation of the Disabled. . . . *Cerebral Palsy Rev.* Mar.-Apr., 1961. 22:2:4-28.

Contents: Familial cerebral palsy, Emil Adler.—Current etiological concepts of cerebral palsy, William A. Hawke.—The early diagnosis of cerebral palsy, Grace E. Woods, Julio Pinto Duarte, Jacques Hariga, and Ben Epstein.—Attempts to meet the problem of long-term care for patients with cerebral palsy, Sherwood A. Messner, A. Ghiora, Mary O'Donnell, Joseph T. Michell, C. D. S. Agassiz.—Current treatment methods in cerebral palsy, Guy Tardieu.—Survivorship in cerebral palsy, Dean W. Roberts.—Vocational habilitation of the cerebral palsied patient, Poul Lütken and Sara Philcox.—Contributions of the sheltered workshop to the habilitation of the cerebral palsied, Alfred Feintuch.—Principles of compensatory work in cerebral palsy of children, M. B. Eidinova.

*Cerebral Palsy Review* is published by the Institute of Logopedics, 2400 Jardine Drive, Wichita 19, Kan. Subscription rates, \$3.00 a year; \$3.50 in Canada and other foreign countries. Single copies, 50¢ each.

See also 513.

### CEREBRAL PALSY—EMPLOYMENT

523. Stephen, Elspeth (*Chailey Heritage Craft School and Hospital, North Chailey, Sussex, Eng.*)

Assessment, training and employment of adolescents and young adults with cerebral palsy: 1. An introductory review. *Cerebral Palsy Bul.* 1961. 3:2:127-134.

In same issue: The adolescent and young adult with cerebral palsy (an editorial), M. E. M. Herford, p. 99-101.—. . . 2. What facilities are needed, R. C. Mac Keith and M. C. O. Bax, p. 135-138.—. . . 3. Facilities now available, M. R. Morgan, p. 139-144.

A review of the literature concerning vocational guidance, training, and placement of adults with cerebral palsy in Great Britain, the U.S., and Denmark reveals no firm figures for the prevalence of the condition in adults. An approximate figure of 0.5 per 1,000 in the general population is estimated. About 25% of these are in open employment but, there again, variations in study methods,

in the samples employed, and in the facilities and conditions of employment make the figure unreliable. American and Danish surveys indicate at least 50% wastage in vocational guidance and training efforts. A clear need for increased facilities for training and guidance is indicated. With at least 70% of adult cerebral palsied expected to be unfit for open employment, the author suggests steps for continued research to improve opportunities for their training and employment.

Dr. Mac Keith (*Guy's Hosp., London*) and Mr. Bax recommend full assessment of the individual with cerebral palsy, realistic vocational guidance with possible modification of the curriculum, use of trained social workers, special training courses, and co-ordinated employment services for school leavers.

Miss Morgan (*Natl. Spastics Soc., 28 Fitzroy Sq., London, W.1, Eng.*) reviews facilities currently available in Great Britain for assessment, vocational guidance, training, employment (open and sheltered), residential care, and home work.

The editorial (p. 99) stresses the need for teamwork in working with the cerebral palsied child, adolescent, or adult. An educational center to bridge the gap between adolescence and adulthood is suggested. Gaps in service are noted.

See also 583.

### CEREBRAL PALSY—MEDICAL TREATMENT

524. Sobkowicz, Hanna (*University Neurological Clinic, Academy of Medicine, Warsaw, Pol.*)

Infirmary rehabilitation of school children with cerebral palsy, by Hanna Sobkowicz, Krystyna Warecka, and Tomasz Zuk. *Arch. Phys. Med. and Rehab.* May, 1961. 42:5:363-370.

Results in treating 10 cerebral palsied children, aged 6 to 15, in a School Rehabilitation Infirmary organized in connection with the Neurological University Clinic in Warsaw are discussed. General gymnastics, resistance exercises for paralyzed muscle groups, and corrective exercises for posture and gait were given, as well as active and passive exercises in the treatment pool. Probamyl was administered after rehabilitation treatment was concluded, in an attempt to maintain achieved results. Neurologic and electromyographic examinations were made during treatment and at a 2-month follow-up examination. An analysis of results suggests the value of a joint pharmacologic and rehabilitation program.

### CEREBRAL PALSY—SURVEYS—GREAT BRITAIN

525. Illingworth, R. S. (*University of Sheffield, Sheffield, Eng.*)

Social status of the parents of cerebral palsied children, by R. S. Illingworth (and others). *Cerebral Palsy Bul.* 1961. 3:2:157-158.

Data on the social status of parents of 417 cerebral palsied children in Bristol and Sheffield, England, were compiled; age of the affected children at the time of the study ranged from a few weeks to 20 years. Social grading was rated according to the work the father was doing at the time of the child's birth. In both areas studied, social status of parents of cerebral palsied children corresponded very closely to that of the general population, with no

## ABSTRACTS

significant difference from the normal distribution of social classes in those regions.

### CHRONIC DISEASE—MARYLAND

#### 526. Ellicott, V. L.

Planning services for the chronically ill; suggestions for a state-wide approach in Maryland. *Monthly Bul.*, Md. State Dept. of Health. Apr., 1961. 33:4:1-4.

Maryland has an established policy of assigning to its State Department of Health almost all medical and hospital services that are accepted state responsibilities. Dr. Ellicott, administrator of the Department's chronic illness program, outlines the broad program of services that should be provided by the state with the co-operation of groups and agencies outside the Health Department. Present needs, suggestions for initiating and expanding services, role of county health units, case-finding technics, the use of pilot projects, and special considerations in metropolitan areas are discussed.

The *Monthly Bulletin* is published by the Maryland State Department of Health, 301 W. Preston St., Baltimore 1, Md.

### CHRONIC DISEASE—PERSONNEL

#### 527. California. State Department of Social Welfare (722 Capitol Ave., Sacramento 14, Calif.)

*Hayward Pilot Training Project for Senior Home Aides; (a guide to development of training courses for employees of homes for the aged)*. Sacramento, Calif., The Dept., 1961. 25 p. (Training aid, no. 19) Mimeo.

Local and state agencies interested in alleviating personnel shortages in nursing homes and homes for the aged should find this guide useful in planning programs similar to the Hayward project. Information on securing community co-operation, planning the curriculum, screening students, scheduling and staffing, and source material is included. A digest of the training manual's contents appeared in the April, 1961, issue of *Chronic Illness Newsletter*, the publication of the American Medical Association's Council on Medical Service.

### COLLEGES AND UNIVERSITIES

#### 528. Bigman, Sidney K. (Office of Social and Environmental Research, Gallaudet Coll., Washington 2, D.C.)

The deaf in American institutions of higher education. *Personnel and Guidance J.* May, 1961. 39:9:743-746.

Data gathered from colleges and universities reporting deaf students in attendance include information on college admission policies affecting their opportunities, their participation in extracurricular activities, and their communication skills and how they are used in following class work. No conclusions can be drawn from so small a study but comments of some registrars have implications for counseling deaf students planning college attendance.

### COLOSTOMY

#### 529. Dericks, Virginia C. (New York Hosp. School of Nursing, 525 E. 68th St., New York 21, N.Y.)

Rehabilitation of patients with ileostomy. *Am. J. Nursing*. May, 1961. 61:5:48-51.

In same issue: I have an ileostomy. . . . Dorothy Ruth White. p. 51-52.

An explanation of the differences in care required by patients with colostomy or ileostomy operations and the role of the nurse in helping patients adjust physically and psychologically to altered bodily function. A technical plan of care for ileostomy patients, used successfully at New York Hospital, is outlined. Advances in medical and surgical management, the availability of psychological help, and the role of ileostomy associations in the patient's posthospitalization adjustment are discussed.

Mrs. White, a free-lance writer, describes the emotional shock and physical complications that she experienced before, during, and following an ileostomy operation.

*See also* 543.

### CONVALESCENCE—RECREATION

#### 530. International Recreation Association

*On the mend; guide to recreation in hospitals*. New York, Internat'l. Recreation Assn. (1961). 32 p. illus.

Planned primarily for use in countries where recreation programs for the ill and handicapped have not been developed, this booklet discusses the initial steps in organizing programs, the facilities and equipment needed, publicizing the program and gaining patients' interest, training and use of volunteers, and activities that might be considered. This small booklet offers a wealth of ideas and advice for recreation leaders beginning from "scratch." Publication and distribution (single copies without cost) to Asia, Africa, and Latin America were made possible through a foundation grant. In the U.S., copies are available from the International Recreation Association, 345 E. 46th St., New York 17, N.Y., at \$1.00 a copy, plus 10¢ to cover mailing costs.

### DEAF—ETIOLOGY

#### 531. Brill, Richard G. (California School for the Deaf, Riverside, Calif.)

Hereditary aspects of deafness. *Volta Rev.* Apr., 1961. 63:4:168-175.

Difficulties in determining accurately the various causes of severe auditory handicap are discussed in the light of past studies bearing on the subject. Findings of a study of the causes of deafness among a population of 656 children attending the California School for the Deaf between September, 1958, and December, 1960, are summarized. Analysis of the data suggests that the proportion of endogenous deafness to exogenous deafness is increasing and possibly has always been higher than reported. Since deaf people tend to marry other deaf people, genetic transmission of deafness may very well increase.

### DEAF—HISTORY

#### 532. Jordan, Thomas E. (St. Louis Univ., St. Louis 4, Mo.)

Historical notes on early study of the deaf. *J. Speech and Hear. Disorders*. May, 1961. 26:2:118-121.

Excerpts from writings of the 17th and 18th centuries are quoted, describing concepts on the causes of deafness, its treatment, teaching problems, educational

philosophy, and some of the results achieved in these early attempts to educate the deaf.

#### DEAF-PSYCHOLOGICAL TESTS

533. Hughes, Robert B. (*Univ. of North Carolina School of Education, Chapel Hill, N.C.*)

Verbal conceptualization in deaf and hearing children. *Exceptional Children*. May, 1961. 27:9:517-522, 510.

Results of the performance of deaf and hearing children of comparable mental ages on a percept testing-concept sorting task (a selected list of words and word concepts) are analyzed. Hearing children performed significantly better with respect to words of higher and lower orders of generality or levels of abstraction. The deaf performed better at the percept level than the concept level. Although there was no significant difference, the orally and acoustically trained deaf performed better than manually trained children. It is recommended that teaching of concepts should include emphasis on what a concept is *not* as well as what it *is*; this is especially important for the deaf since they gain concept knowledge primarily through formal education. The article is based on a doctoral dissertation (*Univ. of Illinois, 1959*) completed under the direction of Dr. T. Ernest Newland.

#### DEAF-SPECIAL EDUCATION

534. O'Connor, Clarence D. (*904 Lexington Ave., New York, N.Y.*)

A study of the integration of deaf children in regular classrooms, by Clarence D. O'Connor and Leo E. Connor. *Exceptional Children*. May, 1961. 27:9:483-486.

A similar but more detailed article covering an analysis of the academic success or failure of 21 students transferred from the Lexington School for the Deaf to integrated classes in regular public or private schools (see *Rehab. Lit.*, June, 1961, #435). The earlier article analyzed records of 18 pupils. Slightly more than half of the 21 pupils were transferred at the recommendation of the Lexington School staff. Approximately one half of the group were unsuccessful in integrated classes.

535. Pugh, Bessie L. (*Institute of Logopedics, Wichita, Kan.*)

Teaching children to use the dictionary. *Volta Rev.* Apr., 1961. 63:4:178-185.

Ten essential skills for effective use of the dictionary as a self-help technic by deaf students are outlined and discussed. Instruction in its use can begin at the preschool level, with picture dictionaries. Methods for teachers of the deaf are explained in detail; children who have received such instruction from the time they enter school should have a fair degree of proficiency in all these skills by the time they reach the sixth grade.

See also 528; 560.

#### DRIVERS

536. Rubin, Nathan (*Insurance Guidance Service of Pennsylvania, Coventry Rd. at Cheltenham Ave., Melrose Park, Philadelphia 26, Pa.*)

Auto insurance for the deaf. *J. Rehab.* May-June, 1961. 27:3:20.

The Stuyvesant Insurance Company, in co-operation with the Insurance Guidance Service of Pennsylvania, is now offering automobile insurance at standard rates to deaf persons in all states east of the Mississippi, except in states having compulsory insurance laws. Only automobiles owned by deaf persons are included in this particular program so that accurate statistics on driving habits of the deaf may be accumulated. Deaf persons interested in the program are invited to write to Mr. Rubin at the above address. The author is the son of deaf-mute parents, is vice-president of the Insurance Guidance Service of Pennsylvania, a member of the Pennsylvania Society for the Advancement of the Deaf, and active in many insurance and charitable groups.

#### DRUG THERAPY

See 499.

#### DWARFISM

537. McCluer, Shirley (*Western Maryland State Hosp., Hagerstown, Md.*)

Rehabilitation of an achondroplastic dwarf with paraplegia, by Shirley McCluer and Ann McElroy. *Phys. Therapy Rev.* May, 1961. 41:5:343-345.

Adaptation of devices and equipment helped the patient to achieve independence in ambulation and activities of daily living. Sudden spontaneous onset of complete paraplegia occurred after a fall early in 1957; on admission to the hospital 8 months later she had only partial return of motor function and was incontinent of bladder and bowel. A brief history of the surgical treatment, physical therapy, and orthopedic appliances employed is given. Adaptations of equipment are discussed in more detail.

#### EMPLOYMENT-SURVEYS-CANADA

See 503.

#### EXERCISE

538. Kasch, Fred W. (*San Diego State College, San Diego 15, Calif.*)

A comparison of the exercise tolerance of post-rheumatic and normal boys. *J. Assn. Phys. and Mental Rehab.* Mar.-Apr., 1961. 15:2:35-40.

The 3-minute step test, using respiratory metabolic and recovery pulse rate data, was chosen as the method for assessing functional capacity in 27 postrheumatic boys and 27 "normal" controls. Findings indicated that the cardiac patients were able to tolerate the exercise without any untoward effects. Advantages of the test over unstandardized jumping tests usually employed by physicians are: it is standardized; it is a simple test easily administered; it is more accurate and reliable than the usual methods of assessment; and tentative results and norms are available for comparative purposes.

539. Rasch, Philip J. (*Coll. of Osteopathic Physicians and Surgeons, 1721 Griffin Ave., Los Angeles 31, Calif.*)

Progressive resistance exercise: isotonic and isometric; a review. *J. Assn. Phys. and Mental Rehab.* Mar.-Apr., 1961. 15:2:46-50, 56.

The fourth of a series of articles from the Biokinetics

## ABSTRACTS

Research Center of the College of Osteopathic Physicians and Surgeons, reviewing the literature on the physiology of progressive resistance exercises and reporting research findings in the field. The author states that strength may be increased by the use of either isotonic or isometric exercise; the cause of the development of increase in strength is disputed but appears to lie in the development of tension. Strength gains appear to be greatest when tension is developed frequently during the course of the training program. Clinical experience suggests that isometric exercises are useful in the therapeutic situation.

## GIRL SCOUTS

540. Girl Scouts of the U.S.A. (830 Third Ave., New York 22, N.Y.)

*Service to the handicapped project, 1960; research report by the Research and Statistics Division. . . . New York, Girl Scouts of the U.S.A., 1961. 21 p. tabs., forms. (Release no. 477) Mimeo.*

Describes a Girl Scout service project conducted in the summer of 1960 with the co-operation of New York University's Institute of Physical Medicine and Rehabilitation, the International Society for Rehabilitation of the Disabled, the International Unit of the U.S. Office of Vocational Rehabilitation, and the National Society for Crippled Children and Adults. Fourteen Rangers from 7 different countries, together with 7 Girl Scouts from the U.S., received a 3-day orientation to rehabilitation techniques and procedures for working with handicapped children and adults, spent 10 days working as junior counselors in 7 Easter Seal camps, then attended a 2-day workshop in New York City to discuss basic principles of rehabilitation, their camping experiences, and how they could use their new knowledge in their own communities. The project is described also in an article by Marion Weller appearing in the Nov., 1960, issue of *American Girl*. In the hope that similar projects will be undertaken by local councils, the Membership Services of Girl Scouts of the U.S.A. is planning to make available in the near future guidance material for planning such programs.

## HEART DISEASE—EMPLOYMENT

541. Michigan Heart Association

Cardiacs at work; a conference on the Heart in Industry . . . Wayne State University, Detroit. . . . *Indust. Med. and Surg.* May, 1961. 30:5:173-194.

Contents: Introduction, Ray R. Eppert.—Keynote address: Rehabilitation of the cardiac patient, Oglesby Paul.—Types of heart problems, Harper Hellems.—Classification of cardiacs, David Gage.—Employment of cardiacs, Max Horton.—The matter of insurance, L. J. Carey.—Legal aspects of the claim, Buell Doelle.—Report on panel discussions: Workshop on rehabilitation, Joseph Schaeffer; What can the physician do to help the cardiac get to work? Martin Bruton; Insurance workshop, L. J. Carey; Legal aspects, Buell Doelle; Employment workshop, Max Horton.—Summary statement, E. A. Irvin.

Co-operating with the Michigan Heart Association in sponsoring the Conference were: Detroit Industrial Nurses' Association, Greater Detroit Board of Commerce, Michigan Industrial Medicine Association, Michigan Manufacturers Association, and personnel divisions of Ameri-

can Motors, Chrysler, Ford Motor, and General Motors corporations.

## HEMIPLEGIA

542. Peszczynski, Mieczyslaw (Highland View Hosp., Harvard Rd., Cleveland 22, Ohio)

Prognosis for rehabilitation of the older adult and the aged hemiplegic patient. *Am. J. Cardiology.* Mar., 1961. 7:3:365-369.

The influence of such factors as degree of motor involvement, sensory deficit, visual disturbances, bowel and bladder control, contractures, local and thalamic types of pain, speech disorders, and abnormalities of higher psychologic functions on the rehabilitation potential of adult hemiplegic patients is discussed. In the older adult or aged patient conventional vocational rehabilitation may not be expected in most instances, but care of the partially dependent disabled person at home can be made easier physically, economically, and socially for the family. This in itself may be an adequate reason for prolonged programs of rehabilitation.

## HEMIPLEGIA—BIOGRAPHY

See p. 208.

## HOMEBOUND—PROGRAMS

See 502; 567; 573.

## INSURANCE

543. White, Dorothy R.

Insurance and the ileostomist. *Ileostomy Quart.* Spring, 1961. 5:2:33-34.

In same issue: Insuring your life (editorial). p. 37-38.

Replies from presidents of four large, long-established life insurance companies to the writer's inquiries brought encouraging news concerning the availability of life insurance for ileostomy and colostomy patients. Although two were extremely cautious in their answers and stated such cases never were considered for standard rates, the other two companies took broader views. One, especially, has never rejected a patient who has had an ileostomy because of ulcerative colitis; standard rates may be granted possibly by the sixth year following insurance, provided the patient has improved. Those interested may obtain the name of the insurance company by writing to the editor, Edith Lenneberg, *Ileostomy Quarterly*, 10 Arlington St., Boston 16, Mass.

The editorial gives the views of an ileostomist who is engaged in the insurance business, explaining the factors governing availability of insurance for such persons and how rates are set.

See also 536.

## LIBRARY SERVICE

544. Illinois Libraries. Apr., 1961. 43:4.

Title of issue: Library services and programs for special needs.

Contents: Preface.—Reading for handicapped children, Olle Wingborg (for digest, see #508 this issue of *Rehab. Lit.*).—Can libraries benefit the mentally retarded? Olle Wingborg.—National Society for Crippled Children

## ABSTRACTS

and Adults; the library revisited, Earl C. Graham.—Trends in children's literature; a need for truth, Betty Ohm.—Guiding high school students; I wear two hats, Mildred Gilmore.—The library and the senior citizen, Rose Vainstein.—Books for retarded readers, Alma Lundeen and Margaret Pendergrass.—The mentally retarded child; a list of books and pamphlets for parents, teachers, and social workers, Alma Lundeen.—Library service to the blind (in Illinois).

*Illinois Libraries* is published by Illinois State Library, Springfield, Ill.

### MENTAL DEFECTIVES

545. Belinson, Louis (*Div. of Mental Health, Missouri State Dept. of Health, Jefferson City, Mo.*)

Modern research in mental retardation. *Mo. Med.* May, 1961. 58:5:478-483.

Research studies investigating such conditions as rubella, erythroblastosis fetalis, mongolism, galactosemia, phenylketonuria, and hepatolenticular degeneration are yielding new knowledge on the causes of mental retardation. Dr. Belinson reviews the findings briefly and discusses objectives of three current studies of major importance; all are concerned with the causes of reproductive wastage, the etiology of fetal loss, and factors during pregnancy that produce central nervous system disease and damage. Research efforts undertaken by the state of Missouri are also noted.

### MENTAL DEFECTIVES—BIOGRAPHY

See 507.

### MENTAL DEFECTIVES—PROGRAMS

546. American Association on Mental Deficiency (*P.O. Box 96, Willimantic, Conn.*)

Program planning for the moderately and severely retarded child; a symposium. *Am. J. Mental Deficiency*. May, 1961. 65:6:695-712.

The five papers presented at the 1960 annual convention of the American Association on Mental Deficiency under the sponsorship of the Sections on Administration and Psychology covered the function and methodology of psychological diagnosis and three "ward programs" employing physical medicine and rehabilitation technics, intensive care treatment, and assignment of a teacher to work intensively with children in the cottage environment. Others discussed the effect of sensory deprivation on retarded children, the roles of professional staff and other employees in the older institution, and the need for closer relationships between the institution and the community.

Contents: Introduction, Maurice G. Kott.—Psychological diagnoses, C. Edward Stull.—Rehabilitation programs, Roger M. Gove.—Psychological programs, Charles C. Cleland.—Administrative planning in an old institution, H. VonBulow.—Administrative planning in a new institution, Robert M. Porter.

547. Windle, Charles D. (*Pacific State Hosp., Pomona, Calif.*)

Caretaker characteristics and placement success, by Charles D. Windle (and others). *Am. J. Mental Deficiency*. May, 1961. 65:6:739-743.

Characteristics of family care homes used by Pacific

State Hospital to provide extrainstitutional care for its patients are described; factors responsible for success or failure of home care are assessed. Data from 45 family care homes showed that caretakers of high socioeconomic status, with an estimated greater interest in the patient and with imputed altruistic motives, were rated more effective by social workers. Findings give little support to previous claims that subnormals are more likely to adjust successfully in "inferior or average" than "superior" family care homes.

### MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

548. Jacobs, Robert (*Laurelton State Village, Laurelton, Pa.*)

Measurement of attitudes to institutionalization, by Robert Jacobs, Alfred Butler, and Leon Gorlow. *Am. J. Mental Deficiency*. May, 1961. 65:6:766-771.

Describes the construction of a scale to measure attitudes of moderately or mildly retarded persons committed to training schools for the retarded. A study was made of 146 female retardates, with IQ's ranging from 50 to 80, aged 14 to 22 years. Minimum institutionalization was 3 months. Analysis of the data indicated the Laurelton Attitude Toward Institutionalization Scale related significantly with adjustment to institutionalization and the more manifest phases of hostile expression.

549. Radaker, Leon D. (*Broad St. School, Butler, Pa.*)

The visual imagery of retarded children and the relationship to memory for word forms. *Exceptional Children*. May, 1961. 27:9:524-530.

Describes the design and procedure of an experimental study of the possibilities of imagery training for retarded children. Results indicated a relatively uniform improvement among most of the 15 children assigned to practice groups. Training apparently permitted children to obtain sharply defined images of words and to discriminate words more effectively. It is suggested that imagery training might prove useful in school subjects other than the language arts since retarded children appear to respond well to such training. The Memory for Word Forms Test, compiled by the writer, is included.

See also 569.

### MENTAL DEFECTIVES—SOCIAL SERVICE

550. Hersh, Alexander (*Woods Schools, Langhorne, Pa.*)

Casework with parents of retarded children. *Soc. Work.* Apr., 1961. 6:2:61-66.

"One-shot" evaluations of retarded children are of little value to parents; the community agency or facility offering services should help parents accept a current interpretation of the child's problems and should provide planned or periodic follow-up. This allows parents time to work through the day-to-day problems and to organize their feelings on a positive basis. Problems unique to parents of retarded children are discussed as well as the social worker's role in counseling. The author is chief parent counselor at the Woods Schools, a private residential facility for children with mental, social-emotional, physical, and academic handicaps.

## ABSTRACTS

551. White, Grace (*Family Service Bureau, 2029 13th Ave., Oakland 6, Calif.*)

What social work has to offer in the field of mental retardation. *Am. J. Mental Deficiency*. May, 1961. 65:6: 772-781.

A member of the Council on Social Work Education discusses functions of the social worker and how they may be applied in management of social problems relating to mental deficiency. She emphasizes the need for inclusion of basic education courses in this field, in both professional training curricula and inservice training programs of agencies. Problems of recruiting competent personnel and utilizing their services effectively are considered. This paper was presented at the 1960 annual meeting of the American Association on Mental Deficiency.

### MENTAL DEFECTIVES—SPECIAL EDUCATION

552. Doll, Edgar A. (*Box 143, Chackanut Dr., Belligham, Wash.*)

The mentally retarded. *Exceptional Children*. May, 1961. 27:9:487-493.

A discussion of the differences between persons with intellectual subnormality and those clinically evaluated as mentally deficient that necessitate different curricula and methods of classroom management in their education. Dr. Doll considers factors determining class placement, class load, the essentials of programs for each group, and qualifications of teachers for the mentally deficient. It is advisable to segregate the mentally deficient in a separate facility by the time they reach adolescence since they fit into neither the elementary school nor the secondary program.

See also 500; 544.

### MENTAL DISEASE—INSTITUTIONS

553. Deane, William N. (*Vermont State Hosp., Waterbury, Vt.*)

The reactions of a nonpatient to a stay on a mental hospital ward. *Psychiatry*. Feb., 1961. 24:1:61-68.

The sociologist assigned to the Vermont Project for the Rehabilitation of Chronic Schizophrenic Patients describes his experiences as a volunteer "patient" on one of the rehabilitation wards at the state mental institution. His reaction to hospital life and to his own role as a patient during his one-week stay leads him to believe that some of the symptomatology of mental patients may be due to the effects of hospitalization and not to mental illness per se. It is thought that hospitalization may also serve to make existing personality traits more intense. Depression, hostility, anxiety, and dissociative reactions were experienced by the author. Dr. Deane is coauthor of the Article of the Month in the June, 1961, issue of *Rehab. Lit.*

### MENTAL DISEASE—PROGRAMS

554. Rice, Charles E. (*VA Hosp., Perry Point, Md.*)

Measuring social restoration performance of public psychiatric hospitals, by Charles E. Rice (and others). *Public Health Rep.* May, 1961. 76:5:437-446.

Describes objectives of the Medical Audit Plan for

Psychiatric Hospitals, a research project to develop a method for appraising effectiveness of public psychiatric hospitals. An attempt is being made to develop a set of goals and to establish measuring instruments for evaluating how completely hospitals achieve them. Social restoration, one of several objectives, is defined and a system for recording relevant hospital-patient events is described. Experimental application of the methodology in a series of state hospitals is planned. If effective in producing meaningful information about hospital organization, the data could be used in planning program adjustments to improve end results of hospital treatment.

555. U.S. Office of Vocational Rehabilitation. *Region V*

*Making the vocational rehabilitation of the mentally ill more effective; report of an OVR Region V conference, Madison, Wisconsin, March 21-24, 1960.* Washington, D.C., Off. of Voc. Rehabilitation (1960). 95 p. diag. Mimeo. Spiral binding.

This report of the second workshop conference held by Region V of the U.S. Office of Vocational Rehabilitation is one of a series on psychiatric rehabilitation sponsored by the Office during the past 2 years.

Contents: Recent developments in vocational rehabilitation for the mentally ill in Region V, Stanley C. Hedstrom.—Making vocational rehabilitation of the mentally ill more effective, Thaddeus P. Krush.—Vocational rehabilitation of the mentally ill, Adaline Johnesse.—The Vermont story, William N. Deane.—The Vermont program for the rehabilitation of the mentally ill, Barbara B. Curtis.—Socio-economic rehabilitation of former mental patients, Else Kris.—The Butler experiment in social psychiatry, J. Sanbourne Bockoven.—Local vocational rehabilitation programs: Illinois, Indiana, Michigan, Ohio, Wisconsin.—Panel: The essential differences in vocational rehabilitation between the physically disabled and the emotionally disabled.—Panel: Staff training needs in vocational rehabilitation for the mentally ill.—Summaries of discussion group reports.

Articles by Drs. Krush and Kris and the panel discussion on differences in rehabilitating the physically and emotionally disabled were summarized in *Rehabilitation Record*, Mar.-Apr., 1961. 2:2:7-18.

Only a limited number of copies of the complete report are available from the Office of Vocational Rehabilitation, Washington 25, D.C.

See also p. 198; 520; 572.

### MENTAL DISEASE—SPECIAL EDUCATION

556. California. State Department of Education (*Sacramento 14, Calif.*)

*The education of emotionally handicapped children; a report to the California Legislature prepared pursuant to Section I of Chapter 2385, Statutes of 1957. . . .* Sacramento, The Dept., 1961. 76 p. figs., tabs.

Results of research programs in California, presented in this report, are believed to be the first major attempt in any state to help schools plan practical preventive approaches to problems of emotionally handicapped school children. The study attempted to find methods for identifying such children before handicaps become intensified. Special programs and procedures to help children achieve

## ABSTRACTS

educationally to their maximum ability were developed and tested. Summarized are the problems involved in educating the emotionally handicapped, the research methods used, and the findings and conclusions. A more detailed description of the research design, procedures and instruments used in identification and diagnosis of children's problems, and types of programs conducted experimentally in various school districts appeared in a preliminary, mimeographed report issued by the State Department of Education in December, 1959.

See also 500.

### MULTIPLE SCLEROSIS

557. Dimsdale, Helen (*Royal Free Hosp., London, Eng.*)

The management of spasticity in multiple sclerosis. *Physiotherapy*. Apr., 1961. 47:4:99-102.

Congress Lecture and Demonstration.

In same issue: Demonstration: Multiple sclerosis; management by physiotherapy, Rona M. Van Leuven. p. 102-108.

A neurologist reviews the literature on the effects of climatic conditions on incidence and severity of multiple sclerosis, the use of treatment procedures involving temperature, and the use of proprioceptive facilitation techniques to relieve spasticity. Medical aspects of treatment for preventing grossly spastic lesions and for reducing spasticity are discussed. Bed rest, drug therapy, the role of surgery in treatment, and management of the spastic bladder are also covered.

The demonstration of physical therapy procedures outlined methods for assessing physical disabilities in multiple sclerosis and the aims and methods of treatment in both the acute and chronic stages of the disease. Includes illustrations of facilitation technics.

### MULTIPLE SCLEROSIS—MEDICAL TREATMENT

558. Foster, J. B. (*Royal Victoria Infirmary, Newcastle upon Tyne, Eng.*)

Multiple sclerosis; a trial of treatment with tolbutamide, by J. B. Foster (and others). *Lancet*. Apr. 29, 1961. 7183:915-917.

Findings reported in the *J. Am. Med. Assn.* in 1960 (see *Rehab. Lit.*, Dec., 1960, #949) prompted a controlled trial of tolbutamide in multiple sclerosis, reported here. Forty patients, divided equally between a group receiving the drug and a group receiving a placebo, were assessed at the end of one month and again at 3 months. There was no evidence that patients receiving tolbutamide benefited; there was wide scatter in individual scores and considerable variability in the apparent results in the two groups. On averaging responses, there appeared to be very little change with or without tolbutamide. (For further discussion of the original *J. Am. Med. Assn.* article, see also *Rehab. Lit.*, June, 1961, #468.)

### MUSCULAR ATROPHY

559. Becker, Abraham (*10 Witherell St., Detroit 26, Mich.*)

Myotonia atrophica; electromyographic and endocrine

studies, by Abraham Becker (and others). *Arch. Phys. Med. and Rehab.* May, 1961. 42:5:319-325.

A detailed case report of a mother, son, and daughter with myotonia atrophica; in the mother onset of the disease was late. Atrophy, in her case, was masked by obesity and coincidental diabetes mellitus. The son and daughter were 32 and 33 years old, respectively. The infrequency of the disease in the family history is difficult to reconcile with the known dominance of inheritance. Characteristic features of the disease—muscular involvement, endocrine changes, cataracts, and cerebral changes—are discussed. In these patients therapy with Meticorten, thyroid, and triiodothyronine produced no subjective or objective improvement.

### MUSIC

560. May, Elizabeth (*Santa Monica City Coll., Santa Monica, Calif.*)

Music for deaf children. *Volta Rev.* May, 1961. 63: 5:220-223, 247.

Reprinted from: *Music Educators J.* Midwinter, 1961.

A music teacher in the elementary schools of Santa Monica describes experiences in teaching profoundly deaf and hard of hearing children. In presenting music, she attempted to acquaint the children with general knowledge of instrumentation and rhythm and to discover what specific technics and knowledge they could pleasantly and profitably learn. Activities included in the program are discussed.

### NEPHROSIS

561. Symposium on the nephrotic syndrome. *J. Pediatrics*. May, 1961. 58:5:607-715.

Contents: Introduction, Jack Metcoff, p. 607-608.—Pathogenesis of the nephrotic syndrome; considerations based on clinical and experimental studies, Walter Heymann, p. 609-619.—The pathology of the nephrotic syndrome, Robert L. Vernier, Howard G. Worthen, and Robert A. Good, p. 620-639.—Studies on the pathogenesis of nephrotic edema; with particular emphasis upon changes in renal hemodynamics and the metabolism of electrolyte and proteins, Jack Metcoff and Charles A. Janeway, p. 640-685.—Physiologic considerations concerning corticosteroid therapy and complications in the nephrotic syndrome, Philip L. Calcagno and Mitchell I. Rubin, p. 686-706.—The physician, the family, and the child with nephrosis, Barbara Korsch and Henry L. Barnett, p. 707-715.

### NEUROLOGY

562. Campbell, E. D. R. (*Hosp. for Sick Children, Great Ormond St., London, Eng.*)

Electrodiagnosis in the neuromuscular disorders of childhood. *Annals Phys. Med.* May, 1961. 6:2:80-88.

Presents a broad classification of diseases in which hypotonia or allied phenomena are the presenting symptoms; only those in Group 3—disorders within the lower motor neuron/muscle-fiber system—are discussed in any detail. The adaptation of electrodiagnostic investigations used with adults is necessary; strength-duration curves are of little practical value because of the lack of co-operation and low pain threshold in children. Testing of over 250

## ABSTRACTS

child patients with the technics described has yielded results comparing favorably with those of other diagnostic methods. The author questions the regarding of amyotonia congenita as a specific clinical entity entitled to a separate name.

**563. Twitchell, Thomas E. (Joseph P. Kennedy, Jr. Memorial Hosp., Boston, Mass.)**

The clinical differentiation and physiological nature of increased resistance to passive movement. *Cerebral Palsy Bul.* 1961. 3:2:110-116.

Clinical differentiation of spasticity, rigidity, dystonia, and the increased resistance to passive movement in various syndromes of cerebral palsy is possible through understanding of the physiological mechanisms that may alter or condition such resistance. The clinical features of various types of increased resistance to passive movement and their physiological nature are reviewed.

*See also* 518; 566.

### OCCUPATIONAL THERAPY

*See* 504.

### OLD AGE

**564. Benjamin Rose Hospital, Cleveland (2073 Abington Rd., Cleveland 4, Ohio)**

Multidisciplinary studies of illness in aged persons; V. A new classification of socioeconomic functioning of the aged, by the Staff of the . . . *J. Chronic Diseases*. May, 1961. 13:5:453-464.

A description and definition of the Index of Independence in Socioeconomic Functioning (Index of ISF) developed at Benjamin Rose Hospital. Information concerning patient resources, needs, and productivity is analyzed to evaluate socioeconomic functioning following illness. Included in this report are examples of its possible use as a longitudinal measure for studies of the socioeconomic impact of illness in various groups of patients and in various illnesses. This article reports one phase of a long-term study of the mental, physical, and social changes in aged persons. For articles reporting findings, see *Rehab. Lit.*, June, 1958, #654; Mar., 1959, #257; and June, 1960, #422.

*See also* 544.

### OLD AGE—SOCIAL SERVICE

**565. Casework with the aging; proceedings of a seminar held at Arden House, Harriman Campus of Columbia University, October 30 to November 4, 1960. *Soc. Casework*. May-June, 1961. 42:5-6:217-290.**

Contents: Introduction, Beverly Diamond.—The aging population; a challenge to social work, Wayne Vasey.—The influence of the social structure on casework practice with the aging, Esther Lazarus.—Basic issues in casework with older people, William Posner.—Diagnostic considerations in casework with aged clients, Helen Lampe.—Use of the relationship in casework treatment of aged clients, Helen Turner.—Guardianship and protective services for older people, Virginia Lehmann.—Responsibility, self-determination, and authority in casework protection of older persons, Edna Wasser.—Summary of workshop discussions, Elinor P. Zaki.—Panel discussion: Administra-

tive responsibility for provision of casework services for the aging, Ollie A. Randall, Moderator.—Implications of the seminar for casework practice, Florence Sytz.—Implications . . . for staff development, Jeanette Regensburg.—Implications . . . for agency planning, Eunice Minton.

### PHYSICAL EFFICIENCY

**566. Meier, M. J. (Div. of Clinical Psychology, Univ. of Minnesota Med. School, Minneapolis 14, Minn.)**

Quantitative effects of basal ganglia surgery on handwriting and gait, by M. J. Meier and F. W. Ayers. *J. Lancet*. Feb., 1961. 81:2:70-73.

A report of an experimental study of the applicability of electronic methods of motion analysis to the assessment of manipulative and travel components of handwriting and gait in persons with known abnormalities of motion. Preoperative and postoperative (6-month) handwriting and gait data are given for a patient who underwent stereotaxic surgery involving the ventrolateral nucleus of the thalamus. Apparatus and assessment conditions are described and the case results reported. Findings support the use of time-sensing technics in the investigation of long-term effects of stereotaxic procedures on quantitative aspects of patterned motion cycles. The article is a later, somewhat condensed version of one by M. J. Meier and L. A. French, M.D., that appeared in the *University of Minnesota Med. Bul.*, June 15, 1960 (31:16:611-622).

*See also* 538.

### PHYSICAL THERAPY—PROGRAMS

**567. Hobson, Elvira P. G.**

Physical therapy in relation to the disabled patient and the home. *Physiotherapy*. May, 1961. 47:5:133-134.

The measure of successful rehabilitation cannot be judged, Miss Hobson believes, by the standard reached on leaving the hospital, but rather by the extent to which that standard is maintained at home and improved over the years. The physical therapist co-operates in planning and executing the treatment program, always taking into consideration the patient's motivation, the attitude of relatives, the actual home surroundings, and the reaction of the community in which the patient lives. The therapist's role in assessing home conditions, counseling the family, and helping the patient to resume an active and productive life in the community is discussed. This is one of the many papers presented at the Eighth World Congress of the International Society for Rehabilitation of the Disabled in 1960.

### PSYCHIATRY

**568. Schechter, Marshall D. (435 N. Bedford Dr., Beverly Hills, Calif.)**

The orthopedically handicapped child; emotional reactions. *Arch. General Psychiatry*. Mar., 1961. 4:247-253.

Four years' experience as consultant to a children's orthopedic hospital has provided the author ample opportunity to observe the variations in emotional response to the congenital or acquired disabilities causing a wide range of incapacity. Clinical material illustrates defense mechanisms, children's and parents' theories of disease, affect states, object relationships, attitudes toward their

## ABSTRACTS

future, and concepts of body image. In spite of ego defects and learning problems in these children, however, their defenses are neurotic rather than psychotic. Intrapsychic and external elements that make dealing with the handicapped child specifically different from other emotional problems of childhood are considered.

### PSYCHOLOGICAL TESTS

569. **Gallagher, James J.** (*Institute for Research on Exceptional Children, Univ. of Illinois, Urbana, Ill.*)

Intellectual patterns of gifted compared with average and retarded, by James J. Gallagher and Leonard J. Lucito. *Exceptional Children*. May, 1961. 27:9:479-482.

A review of the literature yielded confusing results which the writers attribute to a fundamental defect in experimental design. Matching children on mental age scores, they believe, will naturally reveal no differences in performance on tasks involving memory, generalization, and reasoning. They investigated patterns of intellectually bright, average, and retarded children and adults on Wechsler subtests, finding internal consistency in patterns within both the retarded and gifted groups, with negative relationships between the two group patterns. The gifted appear strongest on the factor of verbal comprehension and poorest on tests relating to perceptual organization. The exact opposite was true of the retarded groups. Average groups had patterns different from either of the two extreme samples. Implications for school programming are discussed briefly.

570. **Shontz, Franklin C.** (*Dept. of Psychology, Univ. of Kansas, Lawrence, Kan.*)

A method for evaluating psychosocial adjustment of the chronically ill, by Franklin C. Shontz and Stephen L. Fink. *Am. J. Phys. Med.* Apr., 1961. 40:2:63-69.

Describes a Q-sort rating scale, consisting of a series of descriptive statements referring to various aspects of behavior relevant to rehabilitation and to adjustment to disability, that has been used to measure psychosocial adjustment and to predict success in rehabilitation. Results of some preliminary studies to determine the test's reliability, usefulness, and validity are discussed. Information on the structure of the rating scale and problems involved in establishing its reliability is given in the appendixes.

### PSYCHOLOGY

See 498; 568.

### REHABILITATION—SOUTH AFRICA

571. **Guthrie, D. I.** (*African Explosives and Chemical Industries, Ltd., Somerset West, Cape, S. Africa*)

An experiment in industrial rehabilitation. *S. African Med. J.* Apr. 15, 1961. 35:15:306-310.

The history of industrial rehabilitation is reviewed briefly, with special reference to the work of Sir Robert Jones and others in Great Britain. Two pioneer schemes in South Africa are also cited. A description of the rehabilitation center established at the African Explosives and Chemical Industries factory, a comparatively small plant, is given in more detail. Problems regarding the establishment of the center, its administration, and the adaptation of equipment were encountered but 3½ years'

operation of the center has convinced both labor and management of the value of rehabilitation services.

### REHABILITATION—ADMINISTRATION

572. **Institute for the Crippled and Disabled**, New York (400 First Ave., New York 10, N.Y.)

*Psychiatric pilot project; a joint effort of the . . . and the Division of Vocational Rehabilitation, New York State Department of Education*. New York, The Institute (1961). 25 p. tabs. (Rehab. ser. no. 31)

A report of the first 15 months' experience in providing rehabilitation services to handicapped persons with emotional disabilities through the Psychiatric Pilot Project conducted at the Institute for the Crippled and Disabled. Although a number of projects involving outpatient rehabilitation of mental patients have been established, there had been, prior to the Institute's pilot project, no concentrated study of rehabilitation of mental patients in a comprehensive rehabilitation center. Objectives, procedures, and data on results achieved are discussed. Observations, conclusions, and recommendations are primarily relevant to the Project's evaluation, training, and treatment aspects. Initial results of the completed 28-month Project are given briefly in the addendum.

### REHABILITATION—LEGISLATION

573. **Brightman, I. Jay** (11 N. Pearl St., Albany 7, N.Y.)

The proposed federal legislation for independent living rehabilitation. *Am. J. Public Health*. May, 1961. 51:5: 753-759.

Rehabilitation Acts of 1959 and 1961, considered by Congress, would provide federal grants to states to aid them in rehabilitating persons capable of "independent living" but with no vocational potential. Mr. E. B. Whitten, executive director of the National Rehabilitation Association, which drafted the legislation, believes independent living rehabilitation is a logical extension of vocational rehabilitation programs. Dr. Brightman offers opposing views, stating his reasons for wishing to assign administrative responsibility to public health and welfare departments, at the state and local level. Examples of programs offering independent living rehabilitation services in New York State are cited.

### REHABILITATION—PROGRAMS

574. **Ellwood, Paul M., Jr.** (*Univ. of Minnesota Hosp., Minneapolis 14, Minn.*)

Independent living and the independent physician. *J. Rehab.* May-June, 1961. 27:3:16-17, 39.

The establishment of rehabilitation programs in medical schools, the recruitment of doctors in the medical specialties that provide independent living services, grants to pilot projects attempting to solve administrative problems of rehabilitation facilities and centers, and government funds for state-operated rehabilitation facilities located administratively and structurally in conjunction with universities and medical schools are some of the suggestions offered for improving quality of services. Dr. Ellwood, Jr., is medical administrator of the Elizabeth Kenny Institute in Minneapolis.

See also 506.

## ABSTRACTS

### REHABILITATION— STUDY UNITS AND COURSES

575. Neu, Harold N. (407 S. 16th St., Omaha 2, Neb.)  
Teaching of rehabilitation in a medical school. *Arch. Phys. Med. and Rehab.* May, 1961. 42:5:340-347.

In same issue: Teaching of rehabilitation in a medical school; report of Subcommittee, Comm. on Professional Education, American Rehabilitation Foundation. p. 371-375.—The fovea centralis of rehabilitation education (an editorial), Donald L. Rose. p. 376-377.

The growth of departments of physical medicine and rehabilitation in medical schools has been significant; the teaching of rehabilitation concepts depends upon the interest and enthusiasm of the medical school faculty. Dr. Neu and his associates, with five years of successful experience with a teaching program in rehabilitation under the jurisdiction of a department of physical medicine, conclude that such training should be introduced into the curriculum early, preferably in preclinical years. Not all medical students will accept the rehabilitation concept but the 10 to 15% who do are enthusiastic supporters of this approach to treatment. Teaching methods and curriculum content are discussed.

The American Rehabilitation Foundation (1800 Chicago Ave., Minneapolis 4, Minn.) offers a set of standards for rehabilitation teaching programs, with the objectives considered minimal in the training of medical students.

The editorial by Dr. Rose (*Kansas Univ. Med. Center, 39th and Rainbow Blvd., Kansas City 12, Kan.*) states the need for teaching medical rehabilitation as a specialty with the inclusion of a physiatrist as a faculty member.

### REHABILITATION CENTERS—MICHIGAN

576. House, Frederic B. (326 N. Ingalls St., Ann Arbor, Mich.)

Comprehensive rehabilitation in a general hospital, by Frederic B. House and John C. Walton. *Hosp. Progress.* May, 1961. 42:5:111-114, 194, 196.

Comprehensive rehabilitation, begun in 1957 at St. Joseph Mercy Hospital, Ann Arbor, a voluntary hospital owned and operated by the Sisters of Mercy, includes a full range of medical and vocational rehabilitation services, including a new and unique service—functional capacity evaluation. Discussed are: department organization, adaptation of services to solve complicated rehabilitation problems, the functions of the staff rehabilitation committee and the referring doctor, assistance by outside agencies in the community, and co-operative efforts of sponsoring agencies. Five case histories illustrate the variety of services and types of disabilities treated.

### SHELTERED WORKSHOPS

See 502; 585.

### SOCIAL WELFARE

See p. 206.

### SPECIAL EDUCATION

577. Birch, Jack W. (4260 Coleridge St., Pittsburgh 1, Pa.)

Status of the Council in relation to trends in the educa-

tion of exceptional children. *Exceptional Children.* May, 1961. 27:9:494-498.

Presidential address abstracts from CEC Detroit convention (1961).

Activities of the Council for Exceptional Children support and promote higher quality of teaching in special education, better co-operation among all professions working with exceptional children, growth of parent groups, recognition of the role of the special education teacher, and closer relationships between day school and residential programs and personnel. Co-operation with federal agencies in research, proposed curriculum changes, interest in promoting the production of educational materials, and wider recognition of the needs of the exceptional are also receiving attention of the Council and its membership.

See also 500.

### SPECIAL EDUCATION—EQUIPMENT

578. Nelson, Pauline (Idaho State School for the Blind, 14th and Main Sts., Gooding, Idaho)

Teletraining. *Internat'l. J. Educ. of the Blind.* May, 1961. 10:4:114-116.

A primary school teacher describes teletraining equipment at the Idaho State School for the Blind to teach pupils use of the telephone. The technic has provided training in telephone manners, voice and speaking modulation, and practice in language arts and in building vocabularies. Number concepts and memory were also developed. Learning became meaningful and purposeful and playtime was enriched.

### SPEECH CORRECTION

579. Haspiel, George S. (718 E. Foster St., State College, Pa.)

Maximum Auditory Perception (MAP) Word List, by George S. Haspiel and Richard H. Bloomer. *J. Speech and Hear. Disorders.* May, 1961. 26:2:156-163.

The word list described is a systematic grouping of monosyllabic words used in the English language, containing the various phonetic elements permuted and combined with each other in a sequential order. Its use in training allows the clinician to develop children's ability to discriminate between phonetic elements in word combinations. In working with children with hearing loss, the clinician will find the word list helpful in auditory training, in the diagnosis of discrimination ability, and in the phonic training of students with reading problems.

See also 518; 520.

### SPEECH CORRECTION—PARENT EDUCATION

580. Matis, Edward E. (Speech and Hearing Center, Florence State Coll., Florence, Ala.)

Psychotherapeutic tools for parents. *J. Speech and Hear. Disorders.* May, 1961. 26:2:164-170.

A therapy program conducted by one clinician for the past 8 years in a community speech and hearing center includes parent counseling as a regular feature. Psychotherapeutic techniques used in group therapy have been found applicable in work with parent groups and have helped to remove barriers to growth in children receiving

## ABSTRACTS

speech and hearing therapy. Children from 4 to 12 years of age, referred from city and county schools, are treated in groups of 8 during a 4-week period. The 2-hour daily sessions involve an hour of individual and group work with children and one hour of group counseling with parents. The clinician's methods of handling his role in parent counseling are discussed.

### STUTTERING

581. Kent, Louise R. (*Speech and Hearing Clinic, Oklahoma State Univ., Stillwater, Okla.*)

A retraining program for the adult who stutters. *J. Speech and Hear. Disorders*. May, 1961. 26:2:141-144.

Dr. Dean E. Williams, in 1957, expressed the belief that stuttering is learned behavior and, as such, can be modified. Mrs. Kent discusses a possible application of Dr. Williams's theory to the clinical retraining of the adult stutterer. The client must accept responsibility for changing the way he talks and participate actively in bringing about this change. The goal of retraining is to modify not only the speech behavior of the client but also his beliefs about his ability to acquire more normal speech.

582. Kinstler, Donald Butler (*285 N. Garfield Ave., Pasadena, Calif.*)

Covert and overt maternal rejection in stuttering. *J. Speech and Hear. Disorders*. May, 1961. 26:2:145-155.

Describes the development of a usable scale to differentiate between attitudes of mothers of stutterers and mothers of children with normal speech. The University of Southern California Maternal Attitude Scale consists of 92 statements combining general statements of opinion and statements more directly revealing the mother's own practices. The projective type questionnaire measures overt and covert rejection or acceptance. Findings of the experimental testing of 30 mothers of young male stutterers and 30 mothers of young nonstuttering males revealed significant differences in the pattern of responses.

### VOCATIONAL GUIDANCE

583. Gellman, William (*231 S. Wells St., Chicago, Ill.*)

Achieving productivity for the cerebral palsied. *J. Rehab.* May-June, 1961. 27:3:10-12, 43-45.

By comparing the vocational development of the "normal" or unimpaired person with that of the cerebral palsied, Dr. Gellman points out the vocational needs of

the cerebral palsied whose development in this sphere is delayed or retarded. Most vocational training programs for the cerebral palsied fail to meet their vocational needs because of faulty perspective or lack of skilled professional staff with insight into personality and vocational dynamics. The author outlines a combined training-vocational counseling program that, ideally, would parallel the normal course of vocational development. Services to be included are discussed; the program would be oriented to achievement in the home, at school, and at work.

584. International Vocational Guidance Association (*Miss Morgan, Natl. Spastics Society, 78 Fitzroy Sq., London, W.1, Eng.*)

Vocational guidance for the handicapped; an international seminar in Jerusalem (August 22-September 1, 1960), reported by M. R. Morgan. *Cerebral Palsy Bul.* 1961. 3:2:174-179.

The 150 delegates from 15 countries attending the seminar discussed mutual problems in the areas of assessment of work potential, initial vocational guidance for handicapped children, vocational guidance of handicapped adults, inter-relationships between vocational guidance and other rehabilitation services, vocational training and placement, and co-ordination of all services for the handicapped. Miss Morgan's report includes the highlights of lectures, their titles, and authors.

585. Reiser, Martin (*Jewish Employment and Vocational Service, 5301 Old York Rd., Philadelphia 41, Pa.*)

Views differ on group therapy technique, by Martin Reiser and Marvin Waldman. *J. Rehab.* May-June, 1961. 27:3:23-24.

Selkin and Meyer's recent article on group therapy in the sheltered workshop (see *Rehab. Lit.*, Dec., 1960, #970) laid down rules for successful group therapy. The authors of the current article offer their experiences with more than a year's intensive group psychotherapy at the Work Adjustment Center of the Jewish Employment and Vocational Service, Philadelphia. Their procedures and observations in this research project differ from those of Selkin and Meyer in some respects; special technics and differences in procedure are discussed.

See also 523.

### VOLUNTARY HEALTH AGENCIES

See p. 206; 505.

### VOLUNTEER WORKERS

See 540.

## Events and Comments

### Western Colleges Selected for Teacher Training Programs

REGIONAL TRAINING programs for teachers of handicapped children were designated through secret balloting by representatives of 20 Western colleges and universities. Participants, meeting March 14 to 17 in Phoenix under the auspices of the Western Interstate Commission for Higher Education (*Fleming Law Bldg., University of Colorado, Boulder, Colo.*), applied previously developed criteria in selecting the following:

*For teachers of the visually limited:*

Colorado State College  
San Francisco State College

*For teachers of the cerebral palsied and related neurologically impaired:*

Colorado State College  
Los Angeles State College  
San Francisco State College  
University of Washington

*For teachers of the deaf and severely hard of hearing:*

Colorado State College  
Los Angeles State College  
Oregon College of Education  
San Francisco State College  
University of Arizona  
University of Southern California

The Commission has been working in special education for over two years, supported by the Easter Seal Foundation and the United Cerebral Palsy Foundation. Lloyd Dunn, Ph.D., director of the George Peabody training program for teachers of exceptional children, has been consultant and Hall T. Sprague the co-ordinator at the Commission's headquarters.

### A Comment on

#### Prognosis After Hemiplegia

THE RESULTS OF TREATING 115 hemiplegic patients at this medical rehabilitation centre during the past three years show that positive benefit accrues to a large proportion of the patients. They represent approximately 9% of the total number of patients discharged during this period. This may have some bearing on the results achieved, as it is important to rehabilitate such patients in an active therapeutic community where the balance of long-term to short-term patients is approximately 40% to 60%.

"The patients were 'selected' in the sense that they were referred to this centre for treatment. Only patients with severe hypertension were considered unsuitable. Many patients had lived a life of total dependence for a considerable period before being referred for treatment. Unfortunately many

such patients are only referred to this centre as part of a 'salvage operation' rather than as a planned step in their intensive rehabilitation. The results may be summarized as follows:

Discharged to original work.....	18
Discharged to different work.....	24
Referred to disablement resettlement officer for placing.....	7
Discharged to training centre.....	3
Discharged home—fully independent.....	34
Discharged home—partially independent.....	11
Referred to hospital for further treatment.....	17
Self-discharge.....	1
	115

"An optimum result was obtained in 74.7% of the patients discharged during this three-year period. During 1958 and 1959 a follow-up, after a three-month period, of the 29 patients who were discharged to work showed that 22 were still working, five were again unemployed, and two did not reply.

"All these cases were treated as outpatients on a whole-day basis, five days a week. There is now little doubt that it is only by such intensive overall treatment of the patient, together with a close liaison between all the statutory and voluntary agencies concerned, that really significant results can be achieved.—I am, etc.,

JAMES G. SOMMERSVILLE, Medical Rehabilitation Centre, London N.W.1"—From *Correspondence*, p. 965-966, in *British Medical Journal*, April 1, 1961.

### M. J. Neilson Assumes New Post

MISS M. J. NEILSON on June 1st left the position of secretary of the Chartered Society of Physiotherapy to become the first secretary-general of the World Confederation for Physical Therapy. Both organizations are located at Tavistock House (S.), Tavistock Square, London, W.C.1, England. Miss Neilson joined the staff of the Chartered Society in 1943 as Clerk to the Council and became its chief executive officer in 1947.

### National Group Formed Among Nonprofit Homes for Aged

A NATIONAL association among nonprofit homes for the aged is being sponsored by the National Council on the Aging (345 E. 46th St., New York 17, N.Y.). A Ford Foundation grant of \$140,000 will enable the association to aid homes, voluntary, governmental, or religious, in bettering services and personnel.

### New Pamphlet Discusses Hearing Problems

YOU AND YOUR HEARING, by Norton Canfield, M.D. (*Public Affairs Pamphlets*, 22 E. 38th St., New York 16, N.Y.), published this month, was prepared in cooperation with the American Hearing Society and Royal Neighbors of America. The pamphlet discusses the ear, hearing loss and deafness, their causes and effects, and treatment and hearing aids. Nationally known organizations offering help to those with hearing problems are covered briefly in the back section of the pamphlet. Cost of the pamphlet is 25¢; quantity rates are available on request.

### Western Institute on Epilepsy To Convene in October

THE 13TH ANNUAL Conference of the Western Institute on Epilepsy is to be held October 11 through 14, 1961, at the Granada Hotel and Inn, San Antonio, Texas. Papers to be presented will relate to clinical, biochemical, neurophysiologic, psychological, and electroencephalographic aspects of epilepsy. For additional information, inquiries may be directed to Frank Risch, Ph.D., Secretary-treasurer, at the Institute, 3097 Manning Ave., Los Angeles 64, Calif.

### NYU Medical Center To Offer Rehabilitation Sessions For Nurses and Therapists

DURING THE NEXT academic year, the department of physical medicine and rehabilitation, New York University Medical Center, will offer a seminar for nurses and advanced courses for physical and occupational therapists. Three sessions of its 4-week course "Advanced Physical Rehabilitation Methods for Physical/Occupational Therapists" will be given from November 13 to December 8, 1961; February 5 to March 2, 1962; and April 23 to May 18, 1962. Three sessions of the 3-week "Seminar in Physical Rehabilitation Methods for Nurses" will be held October 16 to November 3, 1961; January 8 to January 26, 1962; and March 26 to April 13, 1962.

Additional information about the courses or the additional clinical observation, practice, and field trips available immediately after the courses may be obtained by writing Mrs. Edith Buchwald Lawton, Director, Postgraduate Education for Paramedical Personnel, at the Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16, N.Y.

## Author Index

Acuff, Sidney H., 520  
 Adler, Alfred, 498  
 Adler, Emil, 522  
 Agassiz, C. D. S., 522  
 Aichhorn, August, 498  
 Am. Assn. on Mental Deficiency, 546  
 Am. Rehabilitation Foundation. Subcomm. of the Comm. on Professional Education, 575  
 Ayers, F. W., 566  
 Back, D. E., 513  
 Barnett, Henry L., 561  
 Barsch, Ray H., 519  
 Bax, M. C. O., 523  
 Becker, Abraham, 559  
 Belinson, Louis, 545  
 Benjamin Rose Hospital, Cleveland, 564  
 Bigman, Sidney K., 528  
 Binet, Alfred, 498  
 Birch, Jack W., 577  
 Bleuler, (Paul) Eugen, 498  
 Bloomer, Richard H., 579  
 Boccius, C. S., 511  
 Bockoven, J. Sanbourne, 555  
 Breuer, Josef, 498  
 Brightman, I. Jay, 573  
 Brill, Richard G., 531  
 Brumm, Günter, 501  
 Bruton, Martin, 541  
 Butler, Alfred, 548  
 Calcagno, Philip L., 561  
 California State Dept. of Education, 556  
 California State Dept. of Social Welfare, 527  
 California. University. Child Amputee Prosthetics Project, 509  
 Campbell, E. D. R., 562  
 Carey, L. J., 541  
 Carlova, John, 504  
 Cattell, James McK., 498  
 Charcot, Jean Martin, 498  
 Cleland, Charles C., 546  
 Connor, Leo E., 534  
 Co-ordinating Council on Rehabilitation (Saskatchewan), 503  
 Cornell University. Graduate School of Business and Public Administration, comp., 505  
 Curtis, Barbara B., 555  
 Dale, Gordon M., 511  
 Deane, William N., 553, 555  
 Dericks, Virginia C., 529  
 Diamond, Beverly, 565  
 Dimsdale, Helen, 557  
 Doelle, Buell, 541  
 Doll, Edgar A., 552  
 Duarte, Julio Pinto, 522  
 Dunn, Lloyd M., 500  
 Eidinova, M. B., 522  
 Ellicott, V. L., 526  
 Ellwood, Paul M., Jr., 574  
 Eppert, Ray R., 541  
 Epstein, Ben, 522  
 Esquirol, (Jean) Etienne Dominique, 498  
 Feintuch, Alfred, 522  
 Fink, Stephen L., 570  
 Fisch, L., 513  
 Fonda, Gerald, 514  
 Forster, Francis M., ed., 499  
 Foster, J. B., 558  
 French, L. A., 566  
 Freud, Sigmund, 498  
 Gage, David, 541  
 Gallagher, James J., 569  
 Gellman, William, 583  
 Ghiora, A., 522  
 Gilmore, Mildred, 544  
 Girl Scouts of the U.S.A., 540  
 Gladstone, Herman, 511  
 Glennon, Vincent J., comp. and ed., 500  
 Goldstein, Robert, 518  
 Good, Robert A., 561  
 Gorlow, Leon, 548  
 Gove, Roger M., 546  
 Graham, Earl C., 544  
 Gurney, Wilma, ed., 509  
 Guthrie, D. I., 571  
 Hall, G. Stanley, 498  
 Hardman, Robert, 512  
 Hariga, Jacques, 522  
 Harris, R. I., 511  
 Haspiel, George S., 579  
 Hawke, William A., 522  
 Hedstrom, Stanley C., 555  
 Hellems, Harper, 541  
 Helmholtz, Hermann von, 498  
 Herbart, Johann Friedrich, 498  
 Herford, M. E. M., 523  
 Hersch, Alexander, 550  
 Heymann, Walter, 561  
 Hobson, Elvira P. G., 567  
 Horton, Max, 541  
 House, Frederic B., 576  
 Hughes, Robert B., 533  
 Hull, Clark L., 498  
 Illingworth, R. S., 525  
 Institute for the Crippled and Disabled, New York, 572  
 Internat'l. Recreation Assn., 530  
 Internat'l. Soc. for Rehabilitation of the Disabled, 506  
 Internat'l. Vocational Guidance Assn., 584  
 Irvin, E. A., 541  
 Iuliucci, Louis, 511  
 Jackson, (John) Hughlings, 498  
 Jacobs, Robert, 548  
 James, William, 498  
 Janeway, Charles A., 561  
 Jauregg, Julius Wagner von, 498  
 Johnnesse, Adaline, 555  
 Jones, John Walker, 517  
 Jordan, Thomas E., 532  
 Jung, C. G., 498  
 Kasch, Fred W., 538  
 Kent, Louise R., 581  
 Kersten, Herbert, 501  
 Kinstler, Donald Butler, 582  
 Koffka, Kurt, 498  
 Köhler, Wolfgang, 498  
 Korsch, Barbara, 561  
 Kott, Maurice G., 546  
 Kraepelin, Emil, 498  
 Kris, Else, 555  
 Krush, Thaddeus P., 555  
 Lampe, Helen, 565  
 Lazarus, Esther, 565  
 Lee, Carvel, 507  
 Lehmann, Virginia, 565  
 Lewin, Kurt, 498  
 Lucito, Leonard J., 569  
 Lundein, Alma, 544; translator, 508  
 Lutken, Poul, 522  
 McCluer, Shirley, 537  
 McDonald, Eugene T., p. 206  
 McDougall, William, 498  
 McElroy, Ann, 537  
 Mach, Ernst, 498  
 Mac Keith, R. C., 523  
 Mase, Darrel J., reviewer, p. 206  
 Matis, Edward E., 580  
 May, Elizabeth, 560  
 Meier, M. J., 566  
 Mercer, Walter, 511  
 Messner, Sherwood A., 522  
 Metcalf, Jack, 561  
 Michell, Joseph T., 522  
 Michigan Heart Assn., 541  
 Minton, Eunice, 565  
 Morgan, M. R., 523, 584  
 Murphree, Oddist D., 516  
 Natl. Assn. of Sheltered Workshops and Homebound Programs, 502  
 Nelson, Pauline, 578  
 Neu, Harold N., 575  
 O'Connor, Clarence D., 534  
 O'Donnell, Mary, 522  
 Ogg, Lorraine, 510  
 Ohm, Betty, 544  
 Paul, Oglesby, 541  
 Pavlov, Ivan Petrovich, 498  
 Pendergrass, Margaret, 544  
 Peszczynski, Mieczyslaw, 542  
 Philcox, Sara, 522  
 Piaget, Jean, 498  
 Pinel, Philippe, 498  
 Pinner, Janet I., 502  
 Porter, Robert M., 546  
 Posner, William, 565  
 Prince, Morton, 498  
 Pugh, Bessie L., 535  
 Radaker, Leon D., 549  
 Radcliffe, Charles W., 511  
 Randall, Ollie A., 565  
 Rasch, Philip J., 539  
 Ray, Issac, 498  
 Regensburg, Jeanette, 565  
 Reiser, Martin, 585  
 Rembolt, Raymond R., 521  
 Rice, Charles E., 554  
 Ritchie, Douglas, p. 208  
 Roberts, Dean W., 522  
 Rodgers, Carl T., 515  
 Roeher, G. Allan, 503  
 Rorschach, Hermann, 498  
 Rose, Donald L., 575  
 Rubin, Mitchell I., 561  
 Rubin, Nathan, 536  
 Ruggles, Ora, 504  
 Rush, Benjamin, 498  
 Sakel, Manfred, 498  
 Schaeffer, Joseph, 541  
 Schechter, Marshall D., 568  
 Sherrington, (Sir) Charles Scott, 498  
 Shipley, Thorne, ed., 498  
 Shontz, Franklin C., 570  
 Simon, Theodore, 498  
 Smith, Carol Cordes, 500  
 Sobcowicz, Hanna, 524  
 Stephen, Elspeth, 523  
 Stern, William, 498  
 Strohm, Bernard R., 510  
 Stull, C. Edward, 546  
 Syracuse University. School of Education, 500  
 Sytz, Florence, 565  
 Tardieu, Guy, 522  
 Taylor, Eugene J., ed., 506  
 Thume, Lee, 516  
 Tickton, Reva S., ed., 502  
 Titchener, Edward B., 498  
 Townsend, M. Roberta, 502  
 Turner, Helen, 565  
 Twitchell, Thomas E., 563  
 U.S. Off. of Vocational Rehabilitation. Region V, 555  
 Vainstein, Rose, 544  
 Van Leuven, Rona M., 557  
 Vasey, Wayne, 565  
 Vernier, Robert L., 561  
 VonBulow, H., 546  
 Voorhees, Arthur L., 515  
 Waldman, Marvin, 585  
 Walton, John C., 576  
 Warecka, Krystyna, 524  
 Wasser, Edna, 565  
 Wasserman, Clara Sedacca, comp., 505  
 Wasserman, Paul, comp., 505  
 Watson, John B., 498  
 Weller, Marion, 540  
 Wertheimer, Max, 498  
 White, Dorothy Ruth, 529, 543  
 White, Grace, 551  
 Wilson, A. Bennett, Jr., 511  
 Windle, Charles D., 547  
 Wingborg, Olle, 508, 544  
 Woods, Grace E., 522  
 Woodward, Everett W., 520  
 World Commission on Cerebral Palsy, 522  
 Worthen, Howard G., 561  
 Wright, George N., p. 198  
 Wundt, Wilhelm, 498  
 Zaki, Elinor P., 565  
 Zuk, Tomasz, 524